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In the course of a school year, schools may face a number of crisis situations, including suicidality, child abuse and neglect, violence, and natural disasters that may impact individual students or create school-wide crises (Collins & Collins, 2005; Mathai, 2002). Each of these crises can pose a threat to student and school safety and, therefore, requires swift and precise action. In addition to the potential lethality of these situations, they also can take an emotional toll on school personnel, potentially leading to increased levels of burnout (Collins & Collins).

Despite the prevalence of crisis situations in schools, there is a dearth of literature referencing school crisis intervention. To date, researchers have not considered important issues such as training in crisis intervention, adequacy of preparation, and self-perceived skills that are necessary to provide crisis intervention in the schools. Because schools serve as the primary provider of child and adolescent mental health services (Burns et al. 1995; Hoagwood & Erwin, 1997), limited training in crisis intervention may leave the professional school counselor less than adequately prepared for the crises they encounter in their schools (Allen et al., 2002).

The current study examined the impact of crisis related issues (type, frequency, and training) on school counselor burnout in order to describe any potential links between level and perceived adequacy of training, perception of crisis intervention efficacy, frequency of crises encountered, self-perceived crisis intervention skills, and level of

burnout experienced. Specifically, results indicated that school counselors worked with a variety of individual crisis situations multiple times during the previous year, but may have gaps in their training experiences regarding crisis topics. On average, participants found crisis training helpful, and some types of crisis training were negatively correlated with levels of burnout.

Findings of this study may inform further research on the potential relationships between crisis training, crisis frequency, and school counselor burnout. Counselor educators and school counselors may use these findings to explore ways to best prepare school counselors for crisis intervention. This exploration may ultimately help current and future school counselors both provide effective crisis intervention and prevent their own burnout.

CRISIS IN THE SCHOOLS: CRISIS, CRISIS INTERVENTION TRAINING, AND SCHOOL COUNSELOR BURNOUT

by

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CHAPTER I

INTRODUCTION

Crisis situations are an unfortunate and not infrequent fact of life in schools. In the course of a school year, schools may face a number of crisis situations, including suicidality, homicidality, physical abuse, sexual abuse, gang violence, and natural disasters that may impact individual students or, in some cases, create school-wide crises (Collins & Collins, 2005; Mathai, 2002). Each of these crises can pose a threat to student and school safety and, therefore, requires swift and precise action. In addition to the potential lethality of these situations, they also can take a severe emotional toll on school personnel, potentially leading to increased levels of burnout (Collins & Collins).

Due to the diverse nature of crisis situations, the focus of this study will be on those crises of a situational and individual nature, hereafter referred to as *individual crises*. A review of child/adolescent and school crisis literature, revealed multiple individual crises commonly referenced. From these crisis topics, a list was developed, which was then examined by experts in the fields of crisis, counselor education, and school counseling. Subsequently, some topics (e.g., substance abuse, grief/loss) were eliminated from the study due to potential overlap and difficulty with clear delineation of when these topics reached "crisis" levels. These questions were then revisited during the field testing of the instrumentation developed for the study. Thus, in this study, individual crises refer to suicidal ideation, suicidal intent, suicidal behavior, physical abuse, sexual

abuse, child neglect, physical aggression/bullying, relational aggression/bullying, gang violence, other school violence, self-injurious behavior, and other severe mental health issues. Although individual crises in the school may occasion school-wide problems (e.g., risk of "copycat" suicides), the focus here will be on the crisis when it occurs at the individual level. This is not to detract from the serious nature of crises that affect the school community on a larger scale. These community/school-wide crises often include the immediate activation of a crisis response team, and therefore are not typically the *sole* responsibility of the school counselor.

Professional school counselors are expected to be a primary force, if not *the* primary force, in crisis response (American School Counselor Association [ASCA], 2000a; Fitch, Newby, Ballestero, & Marshall, 2001). Several national organizations, including ASCA and the Council for Accreditation of Counseling and Related Educational Programs (CACREP) include policies and standards that include professional school counselor knowledge and skill in prevention and crisis intervention strategies (ASCA; CACREP, 2001). Despite increased attention to school violence in the post-Columbine world, however, research on school crisis has lagged behind the demonstrated need for information.

Professional school counselors serve the academic achievement, personal/social, and career development needs of millions of school-aged children from diverse backgrounds. An estimated 10% to 22% of these students face mental health challenges severe enough to impair their functioning (National Advisory Mental Health Council,

1990; National Institute of Mental Health [NIMH], 2000) and, in some instances, occasion crisis situations.

To neglect crisis intervention in school counselor preparation may have far-reaching consequences. It is likely that school counselors will deal with a range of crisis situations, including suicide and suicidal ideation, self-injurious behavior, school violence, child abuse, and severe mental health issues. For example, suicide is the third leading cause of death for those aged 10-24 (NIMH, 2003). Considering that suicide is typically underreported due to lack of evidence, and that the leading cause of death in these age groups is "unintentional injury," it may be possible that suicide accounts for an even higher number of deaths (NIMH). In addition, for each completed suicide, it is estimated that between eight and twenty-five attempts occur (NIMH). Over the past 14 years, estimates of high school students who had seriously considered suicide in the previous 12 months have ranged between 16.9% and 29% (Center for Disease Control [CDC], 2005). Consistent with this, Brener, Krug, and Simon (2000) found that 20.5% of high school students had contemplated suicide in the previous calendar year. The most recent version of the Youth Risk Behavior Surveillance Study (YRBSS) found that 16.5% of students surveyed had created a suicide plan within the previous 12 months and that 8.5% had attempted suicide (CDC). These statistics indicate a strong likelihood that school counselors will work with students who are actively suicidal or engaging in suicidal ideation.

Self injurious behavior (SIB; also called self mutilation) is gaining more attention in the past few years as a problem that many school counselors encounter among

students. SIB has been defined as “deliberate infliction of direct physical harm to one’s own body without any intent to die as a consequence” (Simeon & Favazza, 2001, p. 1). Current estimates of rates of SIB in the adolescent community range between 14% and 39% (Lloyd, 1998; Ross & Heath, 2002), with rates between 40% and 61% demonstrated in clinical populations of adolescents (Darche, 1990; DiClemente, Ponton, & Hartley, 1991). In addition, individuals who self-injure are estimated to be 100 times more likely to die of suicide than the general population (Hawton & Fagg, 1988). Considering the frequency and seriousness of SIB and the risks associated with it, SIB is included as behavior that requires crisis intervention by professional school counselors.

School violence (e.g., homicidality, gang violence, bullying, aggression, and school shootings) is another crisis that professional school counselors may encounter. In one study, 92% of secondary schools reported at least one act of violence during the previous calendar year, with between 7%-9% of students in grades 9 through 12 reporting having been threatened on school grounds with a weapon during the same time period (Devoe et al., 2005). These threats are not limited to students. During the 1999-2000 school year, 9% of teachers were threatened by students, and 4% of teachers were physically harmed by students (Devoe et al.). These reports demonstrate the need for school counselors to be aware of how to handle violent and homicidal behaviors that arise in the schools.

Child abuse presents another type of crisis situation that needs to be addressed in school counselor preparation. Approximately 896,000 incidents of physical and sexual abuse of children and adolescents occur annually (National Clearinghouse on Child

Abuse and Neglect Information, 2004). Education personnel, including teachers, administrators, and school counselors, account for more referrals to child protective services than any other group of professionals or non-professionals (Crosson-Tower, 2003). Because school counselors often are the individuals who follow up on suspicion of child abuse reported by teachers or who identify clusters of symptoms in children with whom they work, being prepared to deal with abuse is vital.

In addition to suicidality, SIB, school violence, and physical and sexual abuse, many school counselors may be working with students who have severe mental health issues. An estimated 10% to 22% of school aged children face mental health issues severe enough to impair their functioning (National Advisory Mental Health Council, 1990; National Institute of Mental Health [NIMH], 2000). Due to the nature of cognitive and emotional issues, mental health problems may be less visible to school counselors than suicidal, violent, or self-injurious behavior; however, mental health problems (i.e., depressive disorders, bipolar disorder, conduct disorder, oppositional defiant disorder, and psychosis) may, in many cases, be related to these behaviors (NIMH). Therefore, it is vital that professional school counselors be able to identify and intervene with students who present with severe mental health issues.

Even with the demonstrated incidence rates of some of these individual crises, school counselors perceive that formal education leaves them unprepared, or at least underprepared, to intervene in crisis situations (Allen et al., 2002). In addition, even those school counselors who report having previous training in crisis intervention report wanting additional training (Mathai, 2002). Over 35% of school counselors reported that

they received no training in crisis intervention in their graduate education (Allen et al.). Allen et al. found that the typical counselor reported that he or she was less than adequately prepared to intervene in a crisis situation, with 18% reporting they were "well prepared" or "very well prepared" and 56% reporting they were "not at all prepared" or "minimally prepared." Similarly, other researchers (King, Price, Telljohann, & Wahl, 1999) found that only 38% of school counselors believed they could recognize a student at risk for suicide. Considering the reported rates of school crises, the level of crisis training in formal training programs may not be meeting the needs of school counselors or the students they serve.

In addition to the potentially lethal consequences for students who are served by school counselors with inadequate training, lack of training and experience also may negatively impact school counselors' levels of health and well being. Burnout is defined in the literature as "a syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment" (Maslach, 1982, p. 3). Although workers in a variety of fields may experience burnout, it typically results from the emotional stress of constantly working with individuals who are troubled, and therefore is most commonly associated with the helping professions (Edelwich & Brodsky, 1980; Maslach; Maslach, Schaufeli, & Leiter, 2001). When faced with the often-constant demands of time and energy from clients and institutions, counselors can become depleted of their physical and emotional resources. This is described in the burnout literature as *emotional exhaustion*. This emotional exhaustion may lead to *depersonalization* as behaviors meant to cope with the demands of the job—behaviors that provide cognitive and emotional distance in order to

protect against exhaustion—lead to cynicism towards and detachment from clients. The final symptom of burnout, *reduced personal accomplishment*, is described as inefficacy or inadequacy in performing specific job functions. Although this may be a further effect of emotional exhaustion and depersonalization, it has been primarily reported as the result of lacking necessary resources to complete job tasks (Maslach, 2003; Maslach, Schaufeli, & Leiter).

Burnout has serious repercussions for school counselors, students, and the school at large. Those in helping relationships who suffer from burnout find themselves frustrated and may, in turn, take out those feelings of frustration and emotional exhaustion on clients (Edelwich & Brodsky, 1980). This leads to low job satisfaction, provision of services that are compromised, and high rates of job turnover (Edelwich & Brodsky; Maslach, Schaufeli, & Leiter, 2001). The triad of emotional exhaustion, depersonalization, and reduced personal accomplishment can manifest in ways that seem to rob counselors of their ability to see each student as an individual with strengths and weaknesses (Maslach, Shaufeli, & Leiter). In fact, counselors suffering from burnout may lose their ability to empathize with their clients (Emerson & Markos, 1996; Skovholt, 2001). Empathy is a core therapeutic condition (Rogers, 1980); therefore, counselors experiencing burnout may, at best, provide ineffective services and, at worst, may be negative and cynical, potentially harming clients (Maslach, Schaufeli, & Leiter).

Although any individual in a helping relationship may be at risk for burnout, it may be argued that those who consistently are working with individuals who are in a crisis state are at higher risk. School counselors have been reported to be particularly at

risk for burnout due to factors including high job stress, role ambiguity, role conflict, and lack of supervision (Kesler, 1990). Recently, Stephan (2005) found that 66% of middle school counselors in a statewide sample reported moderate to high levels of emotional exhaustion and 77% reported a moderate to high level of depersonalization. Another study by Crutchfield and Borders (1997) demonstrated a level of empathy in school counselors low enough to be labeled "subtractive" (p. 224). These studies, though few in number, may suggest a population of school counselors in need of attention and support in order to protect them from burnout.

Frequent exposure to client crises has been cited as a risk factor for burnout among helping professionals (Maslach, 1976). School counselors may experience a high frequency of exposure to crisis and be expected to play an active role in crisis intervention (Allen et al., 2001; ASCA, 2000; Fitch et al., 2001; Mathai, 2002). In a review of the literature, however, no references were found that detailed the effects that crisis and crisis intervention in the schools have on professional school counselor burnout. This study is a first step towards exploring any relationship between crisis intervention in the schools and professional school counselor burnout.

In addition, researchers have indicated that both personal and professional characteristics can serve as risk factors for or protective factors against burnout (Collins & Collins, 2005). Feelings of competency and amount of supervision and consultation have been suggested as protective factors against burnout (Corey & Corey, 1998; Harrison, 1983). If level and frequency of crisis in the schools is to some degree linked to professional school counselor burnout, might level of training moderate negative effects

of crisis on burnout level? Edelwich and Brodsky (1980) suggested that training may provide a remedy for burnout due to the potential for increased knowledge, increased status and power, increased sense of autonomy, and wider range of opportunities that training may provide. In addition, training has been posited as a viable protective factor against burnout because it may lead to increased feelings of competency and provide forums for supervision and consultation (Corey & Corey; Harrison). Therefore, this study also will be a first step in examining the relationship that crisis intervention training may have in moderating the effects of crisis level on burnout of professional school counselors.

Statement of the Problem

Despite the prevalence of crisis situations in schools, there is a dearth of literature referencing crisis intervention in the schools. Among the limited empirical information that is available, most researchers have focused more globally on whether school counselors subjectively perceive they are adequately prepared to deal with crisis situations (Allen et al., 2002; King et al., 1999). That is, to date researchers have not considered important issues such as formal versus informal training in crisis intervention, adequacy of preparation, and self-perceived skills that are necessary to provide crisis intervention in the schools. Often, professional school counselors have more training and preparation for crisis than teachers, administrators, and school staff, and often are vital professionals when crisis intervention is needed. Limited training in crisis intervention, however, may leave the professional school counselor less than adequately prepared for the crises they encounter in their schools (Allen et al., 2002).

Purpose of the Study

The purpose of this study is to describe the individual crises typically faced by professional school counselors and the crisis training and responses used by those counselors. Specific goals include (a) determining the types/frequencies of individual crises faced by school counselors; (b) describing the formal and informal training school counselors have in individual crisis intervention and stabilization; (c) ascertaining school counselors' perceptions of the adequacy of that training; (d) describing the types of resources utilized by school counselors when encountering individual crisis situations; (e) examining school counselors' perceptions of the adequacy of those resources; (f) determining the skills that school counselors need to have in order to effectively intervene when faced with an individual crisis situation; (g) determining whether frequency of crisis intervention contributes to school counselor burnout; and (h) examining whether self-perceived crisis intervention skills, resources, and training moderate the relationship between frequency of crisis intervention and burnout levels.

Professional school counselors face a multitude of school-based situations that could be described as crises, including personal developmental crises, interpersonal developmental crises, disaster events, physical abuse, sexual abuse, student death, suicide, school violence, and gang-related behavior (Collins & Collins, 2005). For the purposes of this study, crisis situations will be limited to incidents that are not as clearly described as developmental, yet effect individual students: suicidality, homicidality, physical abuse, sexual abuse, violence, and other mental health issues. Due to the individual and more private nature of these crises, they may be less likely to come to the

immediate attention of a crisis team at a school or district and, therefore, may be the primary responsibility of the school counselor. In addition, these situations have potentially lethal consequences for the students who face them and thus require immediate, efficient, and effective assistance. To date, no studies have examined the types of training, responses, skills, and resources utilized by professional school counselors encountering individual crisis incidents, the perceived effectiveness of these methods, and the impact these events have on the school counselor.

Research Questions

Specific research questions addressed in this study include the following:

1. What individual crises do school counselors encounter?
2. With what frequency does each of the individual crises occur?
3. What training/preparation do school counselors have in crisis intervention?
4. How helpful do school counselors perceive their crisis intervention training to be?
5. What resources do school counselors use when faced with individual crises?
6. What crisis intervention skills do school counselors identify as most important?
7. How do training/preparation, resources, skills, and levels of burnout vary based on individual (i.e., years of counseling experience, teaching background, demographic variables) and school characteristics (i.e., grade level, socioeconomic composition, number of counselors at the school)?
8. To what extent do frequency and exposure to individual crises predict school counselor burnout?

9. When taken in combination with crisis frequency and crisis exposure, does level of training predict different burnout levels than the relationship that crisis frequency and exposure alone?

Significance of the Study

The current study examines the impact of crisis related issues (type, frequency, and training) on school counselor burnout in order to describe any potential links between level and perceived adequacy of training, perception of crisis intervention efficacy, frequency of crises encountered, self-perceived crisis intervention skills and level of burnout experienced. This study will expand the literature on professional school counselors' experiences with crisis and burnout, as well as contribute to the professional literature on burnout prevention and intervention.

The description of crisis intervention skills necessary for professional school counselors will contribute to the development of competencies for crisis intervention in the schools, the identification of areas for further training in school counselor education programs, and the creation of effective and efficient in-service programs for practicing school counselors. The exploration of crisis intervention training as a factor that might moderate professional school counselor burnout will contribute to both the professional school counselor literature and the burnout literature by providing additional information and direction about potential ways to intervene and prevent burnout.

In addition, although Mathai (2002) researched the frequencies of several major types of crises, the types of formal and informal crisis intervention training, and the perceptions of adequacy of that training, the sample was non-probability and derived by

mass mailings to listservs with an added snowball component to solicit additional respondents. As Mathai reported, this limits the generalizability of the results. Further, Mathai did not consider counselor burnout in her study. In this study, as with Mathai's, the types and frequencies of crisis incidents will be compared with the formal and informal crisis training that school counselors have received. The current study will strengthen the knowledge base by considering the issues with a statewide random sample and adding burnout as a variable. Through this examination, areas of strength and weakness in training can be identified and needs for further professional development can be addressed.

Definition of Terms

The following terms and definitions will be used in this study:

Crisis is defined as "a temporary state of upset and disorganization, characterized chiefly by an individual's inability to cope with a particular situation using customary methods of problem-solving, and by the potential for a radically positive or negative outcome" (Slaikeu, 1990, p. 15). Two types of crisis, developmental and situational, are discussed in the literature (Kanel, 1999). *Developmental crises* are changes encountered during different stages of life and which are experienced by most individuals. Developmental crises include going to school, going through puberty, marriage, and having a child. *Situational crises*, however, are sudden, unexpected, emergency situations that can affect the entire community (Slaikeu). Situational crises will be the focus of this research.

For the purpose of this study, situational crises are further divided into two categories, individual crisis and school/community crisis. *Individual crisis* is defined as suicidal ideation, suicidal intent, homicidal ideation, homicidal intent, physical abuse, sexual abuse, school violence, life-threatening self-injurious behavior, or severe mental health issues. These crises will be the focus of this research project because they typically entail more individual contact between the professional school counselor and the student.

Community/school crisis is defined as community grief reactions to death or any other traumatic event affecting the entire school community that might necessitate critical incident debriefing and mobilization of crisis teams rather than a more individual assessment and intervention.

Crisis intervention is short-term (Hoff, 1984) and has the purpose of "assisting a person or family to survive an unsettling event so that the probability of debilitating effects…is minimized, and the probability of growth…is maximized" (Slaikeu, 1990, p. 6). For the purposes of this study, crisis intervention is defined as a behavior initiated by an individual or individuals in order to ameliorate a crisis situation or aid the individual or individuals experiencing a crisis.

Crisis training is defined as formal academic coursework (i.e., master's-level or doctoral-level courses) and professional development activities (i.e., in-service training, workshops, and conferences) that increase a counselor's crisis intervention knowledge and/or experience of specific crisis topics (i.e. issues of suicidality, child abuse or neglect) or crisis skills training (e.g., Critical Incident Stress Debriefing).

Professional school counselor is defined as an individual who is employed by a K-12 school as a school counselor or a guidance counselor and self-identifies as a school counselor. For the purposes of this study, those who do not identify as school counselors (i.e., school social workers, school psychologists, school psychiatrists) will not be included in the data collection process.

Resources are defined as (1) physical objects (i.e., textbooks, crisis manuals, etc.), (2) in-house personnel (other counselors at the school, on-site administrators, the school nurse, the school social worker, the school psychiatrist, etc.), and/or (3) external personnel (central office personnel, counselors at other schools, community mental health professionals, school attorneys, school counselor educators, etc.) who school counselors might refer to during crisis intervention for consultation purposes, for help in the crisis intervention process, or for support, either for their clients or for themselves.

Organization of the Study

In this chapter, the lack of research regarding crisis intervention training for school counselors was discussed. A statement of the problem, purpose for the study, research questions, significance of the study, and organization of the study were provided. Chapter two contains a comprehensive review of relevant literature on crisis intervention and training, school counselor burnout, incident rates of individual crises in primary, middle, and secondary schools, and formal training of school counselors around crisis intervention. Chapter three includes information on methodology for the current study including research hypotheses, population, participants, instrumentation, procedures, data analyses, and results of a pilot study. Chapter four will include results of

the primary study. Chapter five will contain a discussion of primary research findings, limitations of the study, implications for school counseling and school counselor education, and recommended directions for future research.

CHAPTER II

REVIEW OF RELATED LITERATURE

To discuss crises and crisis intervention in the schools, it is important to consider both how crisis is conceptualized theoretically and the practical impact of crises on school counselors. Therefore, this review of the literature provides information on crisis theory, the types of crises that school counselors may face, and the level of crisis intervention training that school counselors have. In addition, an overview of literature on burnout theory, burnout among individuals who are involved in crisis intervention, and school counselors' experiences of burnout is provided to define burnout and clarify the potential relationship between school crisis and school counselor burnout. Throughout this literature review, evidence behind the rationale for the study will be highlighted and discussed.

Historical Background

The modern development of crisis intervention responses and crisis theory began shortly after a fire killed 493 people at the Coconut Grove Nightclub in Boston on November 28, 1942 (Collins & Collins, 2005; Slaikeu, 1990). Erich Lindemann (1944), one of the psychiatrists who treated the survivors of the fire, documented the varying responses that patients had to the acute grief and trauma they experienced. Throughout his work with the survivors, Lindemann reported that community caretakers might be able to help prevent crisis around bereavement by teaching people how to mourn

appropriately and adequately (Caplan, 1964; Lindemann; Slaikeu, 1990). Gerald Caplan (1964), an associate of Lindemann's who also had worked with survivors of the fire and had ties to both psychiatry and public health, expanded on Lindemann's observations by applying prevention to crisis and psychiatry as a whole, discussing crisis as a construct, and defining crisis and crisis theory.

In his work with psychiatric patients, Caplan (1964) observed that developmental and situational crises that were not handled adequately led to increased mental illness and disorganization, which were then exacerbated by subsequent crises. He also noted, however, that "a successful adjustive experience" during crisis delayed subsequent mental illness and disorganization (1964, p. 35). From this perspective, successful prevention or crisis intervention efforts may lead to personal growth rather than disorganization and mental illness (Caplan 1964; Danish & D'Augelli, 1980; Greer, 1980; Rapopart, 1963; Slaikeu, 1990).

This focus on prevention and early intervention sparked Caplan's (1964) development of Preventive Psychiatry. As defined by the Commission on Chronic Illness (1957), there are three levels of prevention: primary, secondary, and tertiary. The goal of primary prevention is to lower the incidence of illness by preventing occurrence of the illness. The goal of secondary prevention is to reduce the duration and intensity of a disease that does occur. Finally, the goal of tertiary prevention is to reduce the level of impairment that results from a specific illness. Based on this public health concept of a three-part model of prevention and Lindemann's efforts to prevent mental illnesses, Caplan designed Preventive Psychiatry to reduce incidence, duration, and impairment of

mental illness. In his discussion of primary prevention, Caplan laid the groundwork for defining crisis and crisis theory and began the argument for crisis intervention by professional members of a community who come into contact with individuals in crisis.

Definition of Crisis

According to Caplan (1964), crisis occurs when there is disequilibrium between the importance of the problem and the ability to cope with it, that is, the problem is a major threat but typical problem-solving and coping does not work. This causes the person to experience some sort of stress or strain, often including feelings of helplessness, upset, fear, guilt, or anxiety, which is then associated with some form of disorganization in the individual's ability to function (Caplan). Although other theorists have focused on a purer cognitive base (Taplin, 1971) or examination of interpersonal/environmental interactions (Schulberg & Sheldon, 1968), components of what constitutes a crisis have been relatively consistent and include an identifiable precipitating event, emotional disorganization and upset that lasts for a limited period of time, inability to cope using previous methods or strategies, and the potential for either increased or reduced functioning (Slaikeu, 1990). In order to integrate these factors, Slaikeu proposed the following definition for crisis: "a temporary state of upset and disorganization, characterized chiefly by an individual's inability to cope with a particular situation using customary methods of problem solving, and by the potential for a radically positive or negative outcome" (p. 15). This is the definition that will be used in the remainder of this study.

Crisis Theory

Crisis theory has been described and revised by several theorists and researchers, including Caplan (1964), Schulberg and Sheldon (1968), and Taplin (1971). Caplan discussed crisis as the upsetting of equilibrium. That is, people have a specific pattern of being and handling situations, and individuals maintain balance by employing never-fail problem-solving strategies whenever there is a problem that threatens to upset that balance. In the case of crisis, however, the problem is larger and the typical problem-solving strategies fail. This leads to a longer span of trying to rebalance and, when that equilibrium is re-established, the individual's pattern of being may have shifted dramatically. Thus, the crisis is characterized by emotional upset, disequilibrium, and a breakdown in the ability to cope and problem solve (Caplan).

Taplin (1971) critiqued Caplan's (1964) description of crisis in homeostatic terms, arguing that it removed crisis from the larger body of psychological concerns (including personality, emotions, learning, perceptions, and communication) and left it in the realm of psychoanalysis rather than in the proposed public health or preventive approaches (1971). Additionally, Taplin argued that speaking solely about homeostasis removed the ability to discuss and identify whether the crisis and its outcomes were adaptive or maladaptive. Taplin argued that observations of crisis should be based in a more cognitive frame to better identify crisis and ways to research it, identify at-risk populations, and test interventions. Also, Taplin argued that defining crisis from a more cognitive view allows symptoms to be identified around processes like memory, emotionality, and suggestibility in their relation to former functioning; further, crisis can

then be differentiated from stress and from normal reactions to developmental milestones. Taplin also suggested that cognitive perspectives on crisis might lead to improved assessment, pedagogy, and training in crisis intervention for both professionals and paraprofessionals.

Schulberg and Sheldon (1968) described a method of determining individuals at higher risk for crisis by examining the environment (e.g. presence of an event that might cause stress or crisis), the individual's characteristics (e.g. vulnerability to such an event), and the interaction of the two (e.g., exposure of the individual to the event). Through this conceptualization, individuals who might be at higher risk for experiencing crisis can be identified and targeted for primary prevention. In addition, Schulberg and Sheldon devised a method of conceptualizing when positive growth outcomes to a crisis situation would occur. In this formulation, positive outcomes to crisis are most likely to occur when a person can identify and avoid situations that might trigger crises in the future, when a person has self-efficacy around coping and crisis resolution, and when a person has strong social support (Schulberg & Sheldon).

Almost a decade later, Moos (1976) identified four primary influences on crisis theory. First, he posited a Darwinian influence in the human ecological and adaptive aspects of crisis intervention. Because there is a relationship between adaptation to the environment and survival, Moos argued humans must cooperate and commune with each other in order to adapt and survive. Second, Moos identified the influences of human fulfillment and growth theorists, including Rogers (1961) and Maslow (1954). According to this argument, there is an innate motivation to self-actualize and make intentional

progress toward reaching goals in order to enhance life and reduce tension. Third, there is an influence from the developmental life cycle focus, based on Erikson's (1963) psychosocial stages of development. Erikson provided a frame for the struggles and transitions throughout life. The fourth influence, according to Moos, is coping with extreme life stress. This is described through both the accounts of human survival in extreme or crisis circumstances and through the connection between life events or transitions and sudden onset of illness (Holmes & Masuda, 1973; Moos).

Assumptions of Crisis Theory

Although efforts have been made to describe crisis theory and its influences, many have criticized crisis theory as a set of assumptions rather than a pure, data-driven theory (Slaikeu, 1990). Despite limited empirical study of crisis theory in its entirety, the concepts are theoretically sound, and many of the assumptions have been tested in empirical studies. The assumptions of crisis theory as described by Slaikeu are described in detail in the following section.

Precipitating event. A crisis needs an identifiable beginning tied to an event in the life of the individual (Caplan, 1964; Halpern, 1973; Rapopart, 1962; Slaikeu, 1990). Crisis situations can range from national disasters and large scale violence that almost universally affect those both directly and indirectly involved to incidences of bullying in schools, which are often accepted as a basic part of adolescence (Sandoval, 2002). Further, similar instances may trigger a crisis in one individual and not in another, or may trigger crises of greater or lesser intensity in different individuals (Rapopart, 1962). For each crisis, however, the assumption is that a precipitating event exists.

Situational and developmental types. As described in the literature, crisis can take two forms: developmental and situational (Allan & Anderson, 1986; Caplan, 1964; Collins & Collins, 2005; Kanel, 1999; Parad, 1965; Slaikeu, 1990). Developmental crises (also called maturational crises) are normal and expectable parts of growth and development (Rapopart, 1963). The most common examples of developmental crises are psychosocial crises described by Erikson (1963), such as industry versus inferiority, identity versus role confusion, and intimacy versus isolation. When an individual is unable to cope with a new developmental task and becomes overwhelmed, a developmental crisis may result (Collins & Collins). These developmental tasks and crises have the potential to be resolved adaptively, resulting in the personal growth of the individual, or maladaptively, resulting in reduced functioning of the individual (Erikson).

Situational crises involve a sudden and unexpected onset of an emergency nature that is threatening to at least the individual, if not the larger community (Slaikeu, 1990). Rape, natural disaster, diagnosis of a serious illness, car accident, and death of a loved one are examples of situational crises. As with developmental crises, the opportunity exists both for personal growth and the risk of lowered functioning (Slaikeu).

Cognitive aspects. Several researchers have described a cognitive impact of crisis (Rapopart, 1965; Taplin, 1971). In this sense, crisis occurs when individuals receive new information that they either cannot accommodate or that they find overwhelming (Taplin). The specific cognitions of an individual around how the precipitating event is perceived can be clinically significant (Slaikeu, 1990). Specifically, the perception of a precipitating event as a threat to an individual's physical or emotional well-being, a loss,

or a challenge to the individual's capabilities will mediate the response an individual has to the crisis situation (Rapopart, 1965).

Disorganization and disequilibrium. Caplan (1964) originally described the emotionality and disequilibrium that an individual in a crisis state experiences. In subsequent research, Halpern (1973) described ten symptoms that those in a crisis state experienced significantly more frequently than those not experiencing a crisis, including feelings of tiredness/exhaustion, feelings of helplessness, feelings of inadequacy, feelings of confusion, physical symptoms, feelings of anxiety, disorganization of functioning in work relationships, disorganization of functioning in family relationships, disorganization of functioning in social relationships, and disorganization in social activities. With such widespread symptoms that affect not only the individual, but also her or his work, family, and social relationships, it is possible that those experiencing crisis experience decreased functioning and disorganization in different activities and systems that might otherwise have served as supports or coping mechanisms.

Breakdown in coping. One of the defining criteria of a crisis is the inadequacy of former coping skills and problem-solving methods (Caplan, 1964; Slaikeu, 1990). Coping has two components, a problem-solving component to help change the situation and an intrapersonal component that focuses on self-management of feelings and reactions to the situation (Lazarus, 1980). A situation that triggers a crisis overwhelms those components. Not only can the individual not problem-solve, but he or she also is unequipped to manage the intrapersonal responses that accompany the precipitating event (Slaikeu).

Vulnerability and reduced defensiveness. An assumption of crisis theory is that the person in crisis has increased vulnerability and reduced defensiveness. These characteristics might, at times, have positive ramifications when the result is increased suggestibility and openness to new ideas that increases the potential for growth and change (Halpern, 1973; Slaikeu, 1990; Taplin, 1971). Interestingly, the Chinese character for crisis is the combination of two other symbols—the first representing danger and the second representing opportunity, which serves to reinforce the potential for both negative and positive impacts of crisis situations. As former methods of coping no longer work, individuals in a crisis state may be more willing to try new strategies and activities to help resolve the crisis, potentially bringing about new levels of understanding self and others and increased functioning once the crisis is resolved.

Crisis is more than stress. One of the key discussions in early crisis literature surrounded the difference between stress and a crisis. Viney (as cited in Slaikeu, 1990) offered four distinctions between stress and crisis. First, methods of coping during crisis situations are different from those used during periods of stress, with the focus being more on personal rather than familial or social supports. Second, individuals faced with crisis situations appear to be less defensive and more open to suggestions (Halpern 1973; Taplin, 1971). Third, the outcome of crisis can be either positive or negative, whereas stress is typically seen only as negative. This distinction may seem contradictory to literature on eustress, which is described as a level of stress that promotes "positive psychological states" (Edwards & Cooper, 1988). However, the literature on eustress is limited, and the majority of the literature on stress focuses on the negative aspects of

stress (Nelson & Cooper, 2005). In addition, there appears to be a lack of clarity about whether eustress as a construct is a) a moderate and "optimal" level of stress, b) an individual's response to a perception of a stressor as positive, or c) some combination of the two (e.g. Edwards & Cooper; Selye, 1987; Suedfeld, 1997), so until further research is done on eustress, it seems safe to assume that stress is primarily a negative construct, whereas crisis can result in either positive or negative outcomes. Finally, crisis is more time-limited and has an identifiable onset (Caplan, 1964), whereas stress may be chronic and increase over time. Echoing Viney, Dixon (1979) differentiated crisis from stress by stating that crisis is "generally unexpected, the adverse reaction is acute, temporal in nature, and emotionally debilitating" (p. 20).

Time limits. Unlike the stress response, an individual in a crisis state typically restores equilibrium within four to six weeks (Caplan, 1964; Danish & D'Augelli, 1980). This is not to say that the crisis has been adaptively resolved in this time frame. Rather, it is the disorganization and disequilibrium that are time limited (Slaikeu, 1990). The restored equilibrium of the individual may be either more or less healthy than it was prior to the crisis (Caplan). For example, the new problem-solving pattern established after the crisis may involve irrational thoughts or a detachment from life experiences, leading the individual to avoid stressors and leaving her or him more susceptible to future mental health issues (Caplan).

Phases/Stages. Several theorists have described stages or phases of crisis (Caplan, 1964; Horowitz, 1976). Both Caplan (1964) and Horowitz (1976) presented models of stages or phases through which individuals experiencing a crisis may move. Although the

two address similar aspects, Caplan's model described the steps preceding emotional disorganization, while Horowitz's model focused more on the steps made to resolve a crisis and restore equilibrium.

Caplan described a four stage process as follows:

1. A precipitating event causes an increase in tension, which the individual attempts to solve using habitual problem solving responses;

2. Failure of these problem-solving responses, when combined with the continued impact of the precipitating event further increases feelings of upset and ineffectuality;

3. The increase in tension causes the individual to turn to other problem-solving resources. The tension may abate at this point due to any of the following: reduction in the external threat, redefinition of the problem, success of new coping strategies, or giving up goals that are unobtainable;

4. If none of those tactics works, the tension increases to a breaking point, which results in severe emotional disorganization, or the crisis state (Caplan, 1964)

Horowitz (1976) described a similar set of stages. According to his theory, an individual experiences *Outcry*, which is an initial reaction to a precipitating event. *Outcry* may result in either *Denial*, described as a blocking of that impact from consciousness, or *Intrusiveness*, described as a constant and involuntary stream of thoughts and feelings about the precipitating event. At that point, individuals may vacillate between *Denial* and *Intrusiveness* multiple times, or may skip the *Denial* phase altogether. At some point, the individual moves to *Working Through* the crisis where they are identifying, expressing, and venting their cognitions, emotions, and images of the precipitating event. Once

individuals have finished *Working Through* the crisis, they can then integrate those experiences into their lives, thus reaching *Completion*. At that point, disorganization and disequilibrium of the crisis has ended (Horowitz, 1976).

Outcome of crisis. Crisis has been described as unique from other types of life stress due, in part, to potential for an end result that is either adaptive or maladaptive (Caplan, 1964; Darish & D'Augelli, 1980; Greer, 1980; Rapopart, 1963; Slaikeu, 1990). Although some researchers have suggested there may be a return to the status quo (Sugarman & Masheter, 1985), others have suggested that this happens rarely and that outcomes are typically more polarized in nature (Slaikeu, 1990).

Not necessarily mental illness. The final assumption of crisis theory is that anyone can experience a crisis and, therefore, it is not necessarily indicative of mental illness (Slaikeu, 1990). Although many of the symptoms may present as similar to symptoms of common psychological disorders, the idea that any individual can have a developmental or situational crisis cautions against defining crisis reactions as pathological. Indeed, Slaikeu suggests that the emotional disorganization provoked by a crisis experience is, rather, a "normal response to an abnormal circumstance" (p. 29). The framework provided by Caplan as a temporally bound instance of disorganization marked by the disruption and then subsequent return to homeostasis suggests that symptoms that fit this definition of crisis are not pathological and, therefore, are not indicative of mental illness.

Crisis in the Schools

Crisis in the schools can take many forms, including suicidal behavior or ideation, self-injurious behavior, school violence, bullying, gang violence, child abuse and neglect,

and severe mental health issues (e.g. Collins & Collins, 2005; Sandoval, 2002). In the following section, each of these types of crisis will be defined, and the prevalence rates and consequences will be described.

Suicide

Suicide has been defined in the literature as a death where there is evidence of both self-infliction and the intent to die (Jobes, Berman, & Josselsen, 1987). There are a range of behaviors and cognitions related to suicidality that school counselors may face. In the following paragraphs, definitions and terms commonly associated with suicide will be defined and the prevalence of suicidal thoughts and behaviors will be discussed.

A basic set of terms to define suicidality has been proposed by O'Carroll and his colleagues (1996) to standardize the language used by those involved in research, intervention, and prevention of suicide. This nomenclature distinguishes thoughts of suicidal behavior from suicidal behavior. Key definitions include:

Suicidal ideation – "any self-reported thoughts of engaging in suicide-related behavior" (p. 247).

Suicide-related behavior - potentially self-injurious behavior that has evidence of either 1. intention to take one's own life (*Suicidal Act)* or 2. the appearance of intention to take ones own life in order to accomplish some alternative goal (*Instrumental Suicide-Related Behavior).*

Suicidal Acts include those that result in death (*Completed Suicide*), those that result in injury (*Suicide Attempt with Injuries)*, and those that do not result in injury. All types of *Suicidal Acts* include the evidence of some level of intention to die.

Instrumental Suicide-Related Behaviors lack the evidence of intention at any level to die and may include behaviors that would create the appearance of intention to die in order to accomplish an alternate goal (e.g., manipulation, punishment of others, receiving attention, receiving help). *Suicidal Threats* are a subcategory of *Instrumental Suicide-Related Behaviors* that includes nonverbal or verbal communication that would suggest a *Suicidal Act* or other suicidal behavior might occur in the future.

Distinguishing components of these definitions include the presence of cognitions about suicide, the presence of some level of intent to die, and the presence of behaviors that demonstrate the potential for self-harm. For the purposes of this study, the following terms will be used in the discussion of suicide:

Suicidal Ideation - having thoughts of taking one's own life.

Suicidal Intent - having thoughts of taking one's own life including a specific plan and the desire to follow through on those thoughts.

Suicidal Behavior - having thoughts pertaining to taking one's own life accompanied by an action specifically meant to cause severe harm or death.

Suicide is the third leading cause of death for those aged 10-24 (NIMH, 2003). It may be possible, however, that suicide accounts for an even higher number of deaths than have been reported (NIMH). The leading causes of death in individuals aged 10-24 is "unintentional injury," and the second leading cause of death in individuals ages 15-24 is homicide (NIMH). There is the possibility that "accidental" deaths (e.g., drug overdoses, motor vehicle accidents, firearm accidents) and even some homicides were actually

suicides that lacked sufficient evidence of suicidal intent (Hart & Keidel, 1979; Hawton, 1986).

The NIMH (2003) has estimated that there are between eight and twenty-five attempts that occur for each completed suicide. In a meta-analysis of population-based studies published worldwide regarding adolescent suicidal behavior, suicidal ideation, and deliberate self-harm, researchers found that a mean of 9.7% (95% CI, 8.5–10.9) of adolescents reported having made a suicide attempt, with a mean of 6.4% (95% CI, 5.4—7 .5) reporting having made a suicide attempt in the previous 12 months (Evans, Hawton, Rodham, & Deeks, 2005). This percentage is striking, however, because the studies included were non-anonymous studies, anonymous studies, and interviews, and reported incidence rates were significantly lower in studies using interviews (Evans et al.). Based on this, it appears that response formats impact reporting of suicide attempts. Additionally, Evans and his colleagues reviewed studies dating from 1963 to 2000. Since 1950, the suicide rate for adolescents has increased approximately 300% (Poland & Lieberman, 2003), Given that the results of the meta-analysis performed by Evans and colleagues are based on studies completed between 1963 and 2000, it is possible that these results may underestimate the prevalence of current completed and attempted suicides.

In a recent study by Mathai (2002), school counselors reported a mean of 7.80 (range reported of 0-138) instances of suicidal ideation expressed by students over the previous three years, a mean of 2.43 (range of 0-60) suicidal gestures by students over the previous three years, and a mean of 0.15 (range of 0-7) completed suicides by students

over the previous three years. These figures seem to contrast with other estimates of suicidal ideation and behavior. For example, estimates of high school students who had seriously considered suicide in the previous twelve months range between 16.9% and 29% over the past 14 years (Center for Disease Control [CDC], 2005). Even at the lower end of this rating, that would amount to approximated 30 students in a school of 500 who had seriously considered suicide over the previous twelve months. Similarly, Brener, Krug, and Simon (2000) found that 20.5% of high school students had contemplated suicide in the previous calendar year, and Evans and his colleagues reported a mean rate of suicidal ideation of 19.3% (95% CI, 11.7—27.0) over the previous 12 month period. The most recent version of the Youth Risk Behavior Surveillance Study (YRBSS) found that 16.5% of students surveyed had created a suicide plan within the previous 12 months and that 8.5% had attempted suicide (CDC). The most obvious difference in methodologies is that the Mathai study relies on school counselor report as opposed to other studies that have primarily used anonymous self-report or interviews. More research is needed to understand further the discrepancy between student reports and school counselor reports, although it is possible that in schools where counselors have high caseloads, students who are struggling with suicidal ideation may not always come into contact with school counselors.

Prevalence rates of suicidal behavior, including suicidal ideation, suicide attempts, and suicide completions may differ by age, sex, and ethnicity. Suicide occurs relatively infrequently prior to age 10, but increases thereafter (Davis & Brock, 2002). For example, according to the NIMH (2004), there were 272 completed suicides in 2001

among youth ages 10-14 (an incidence rate of 1.3/100,000), with males completing suicide three times more often than females. During this same, there were 1,611 completed suicides in adolescents aged 15-19 (an incidence rate of 7.9/100,000), and 2,360 completed suicides in young adults aged 20-24 (an incidence rate of 12/100,000), with males completing suicide five and seven times more often than females, respectively (NIMH). Although males complete suicide more frequently than females, females report attempting suicide three times more often than males (NIMH).

Although suicide and suicidal behavior differ by age and gender, there also is evidence of differences by ethnicity (CDC, 2005; Davis & Brock, 2002). In the most recent Youth Risk Behavior Surveillance System [YRBSS], Hispanic females reported seriously considering suicide (23.4%) and making a suicide plan (20.7%) at higher rates than White females (21.2% and 18.6%) and Black females (14.7% and 12.4%; CDC). Hispanic males reported seriously considering suicide (12.9%) and making a suicide plan (14.6%) at rates similar to White males (12.0% and 13.9%, respectively). Black males reported lower rates of seriously considering suicide (10.3%) and making suicide plans (8.4%). Despite the lower reported rates of suicidal ideation in Black males, the reported rate of suicide attempts in adolescent Black males has increased over 200% from 1991 to 2003, and reported rates of suicide attempts requiring medical attention has increased 1300% over the same period (CDC, 2004). Suicide and suicidal behaviors, therefore, are a significant public health problem in the adolescent population in the United States.

Self-Injurious Behavior

Self-injurious behavior [SIB], sometimes also referred to as self-mutilation, is defined as "the deliberate infliction of direct physical harm to one's own body without the intent to die as a consequence" (Simeon & Favazza, 2001, p. 1). SIB can take many forms, including burning, cutting, slicing, interfering with wound healing, swallowing of sharp objects, hair-pulling, punching or hitting oneself, and self-amputation (Favazza, 1987; Simeon & Favazza). Due to the deliberate and self-inflicted nature of the injuries resulting from SIB, it can be confused with suicidal behavior. A person who is self-injuring, however, has no intent to die (Alderman, 1997), which distinguishes SIB from the suicidal behaviors described by O'Carroll and his colleagues (1996).

Shneidman (1985) reported several distinguishing characteristics between SIB and suicidal behavior. According to Shneidman, the stimulus for SIB is intermittent pain, whereas the stimulus for suicide is unbearable pain. When faced with this stimulus, an individual participating in SIB would self-injure with the goal of changing those feelings, with the purpose of relieving the intermittent pain; an individual presenting with suicidal behavior would be attempting to end, rather than alter those feelings, providing a permanent solution to unbearable pain.

Experts report multiple reasons an individual might self-injure. For some, it may be pathological (i.e., self-injury is a criteria for Borderline Personality Disorder; American Psychiatric Association [APA], 2000). Others describe SIB as a method of coping with or regulating emotions, punishing oneself, dissociating, expressing oneself, coping with stress or controlling painful memories (Alderman, 1997; Favazza, 1987;

Favazza & Simeon, 1995, Ross & Heath, 2002). Although SIB is not a suicide attempt, the behavior can be destructive and potentially lethal. In addition, individuals who self injure have a 100 times greater risk of dying due to suicide than individuals who do not self-injure (Hawton & Fagg, 1988).

Reports of gender differences in self-injury are conflicting. Generally, it is believed that more females than males self-injure (Ross & Heath, 2002). Multiple researchers, however, have recently reported that there may be no gender difference in rate of SIB, and that the reported gap may be due to male injuries being dismissed or mis-labeled as "macho outbursts" (Ross & Heath, 2002; White Kress, Gibson, & Reynolds, 2004).

Although it is difficult to estimate the prevalence of SIB, rates appear to be increasing (Wester, Hall, & MacDonald, 2005). Among community samples of adolescents, reported rates of SIB have ranged from 14%-39% (Lloyd, 1998; Nock & Prinstein, 2004; Ross & Health, 2002). Adolescents in inpatient facilities have typically reported higher rates, ranging from 40%-61% (Darch, 1990; DiClemente, Ponton, & Hartley, 1991). Recently, community and private practice counselors reported seeing a mean of 12.17 (*SD*=28.38) clients per month who self-injure (Wester, Hall, & MacDonald, 2005). Although people of all ages may self-injure, onset of SIB has been reported to be approximately age 13, with a range from ages 6-17 (Nock & Prinstein). With these reported levels of prevalence in the community and the relatively young onset of SIB, it is reasonable to assume that professional school counselors may work with students who self-injure.

School Violence

Although students are more likely to be victims of violence away from school than at school (DeVoe, Peter, Noonan, Snyder, & Baum, 2005), incidences of violence in schools still occur all too frequently. Any violence at school is disruptive to the educational process and affects not only the involved students, but also witnesses and the community at large (Henry, 2000). During the decade between July 1, 1992 and June 30, 2002, there were 462 violent deaths of students, faculty, staff and school-aged non-students that occurred on school grounds, in transit to or from school, or at a school sponsored event (DeVoe et al.). Of these deaths, 261 were homicides of school-aged children and adolescents (DeVoe et al.). In the 2002-2003 school year, of the 54.2 million students enrolled in elementary, middle, and secondary schools, 15 students ages 5-19 were victims of a school-related homicide (DeVoe et al.). In comparison, during the same decade period, school-aged students (between ages 5 and 19) were more than 70 times more likely to be murdered away from school than at school (DeVoe et al.)

Although students have a greater likelihood of being attacked away from school than at school, typically students report being more fearful of being attacked at school or in transit to and from school than they were away from school (DeVoe et al., 2005). Between five and seven percent of students have reported skipping school or avoiding specific locations at school because they were afraid.

School-related homicide is not the only type of violent crime that affects our school systems. For the purposes of definition, the term *serious violent crime* will be used to describe incidents including rape, sexual assault, aggravated assault, and robbery and

the term *violent crime* will include simple assault and serious violent crimes. During the 1999-2000 school year, 92% of secondary schools, 87% of middle schools, and 67% of elementary schools reported at least one violent incident, and 29% of secondary schools, 29% of middle schools and 14% of elementary schools reporting at least one incident of serious violence (DeVoe et al., 2005). In 2003, students aged 12-18 were the victims of approximately 740,000 violent crimes and 150,000 serious violent crimes (DeVoe et al.). These numbers actually indicate a *decrease* in violent crime between 1992 and 2003 (DeVoe et al.). Although the amount of students reporting carrying a weapon on school property declined approximately 50% from 1993 to 2003, six percent of students report carrying weapons on campus, and in 2003, 12% of males and 6% of females in grades 9-12 reporting being threatened or injured with a weapon on school grounds (DeVoe et al.).

Often, school violence is connected to both bullying and the presence of youth gangs (e.g. Chandler, Chapman, Rand, & Taylor, 1998; Hazler & Carney, 2000; Howell & Lynch, 2000; Vossekuil, Fein, Reddy, Borum, & Modzeleski, 2002). The following two sections detail the specific ramifications of bullying and youth gangs and their relationship to school violence.

Students are not the only victims of school violence. Teachers also report multiple instances of violent crimes. Annually, teachers are the victims of approximately 65,000 violent crimes and 7,000 serious violent crimes (DeVoe et al., 2005). Between 8%-11% of teachers are threatened with injury by students each year, and as many as five percent are physically attacked by students annually (DeVoe et al.)

Bullying

Bullying has been described as a type of terrorism, with attacks that are unprovoked and intended to be hurtful or harmful to the intended victim(s) (Ross, 2002). There are two main components of the definition of bullying in the literature—the bully having a position of power or strength over the victim and the attacks being sustained over a prolonged period of time (Farrington, 1993; Olweus, 1993). Although bullying has historically been thought of as a primarily male behavior involving physical threats, intimidation, and behaviors (Olweus, 1978), more recent researchers have indicated that females may bully as much as males, but that it comes in a different form that is more covert in nature and relies more on exclusion and gossip than on physical intimidation (Forero, McLellan, Rissel, & Bauman, 1999; Olweus, 1993). Crick and her colleagues have defined this type of female-dominated bullying as *relational aggression* (Crick & Grotpeter, 1995). For the purposes of the discussion of bullying in the schools, its prevalence, and its effects, the term *physical aggression* will be used to describe threats, behaviors, and intimidation of a purely physical nature (e.g., punching, tripping, threats of violence) and *relational aggression* will be used to describe psychological and verbal aggression (e.g., activities intended to exclude, spread gossip, or alienate victims). In addition to these two main types of bullying, there are more recent reports of newer methods of using technology to bully (Health Resources and Services Administration [HRSA], 2005; Willard, 2005). This type of bullying has been referred to as *cyberbullying* and refers to using instant messaging, chat rooms, email, or other technological methods to threaten, exclude, or gossip about another individual (HRSA).

Bullying is thought to be one of the more constant of human behaviors (Olweus, 1979) and often starts in preschool (Moffitt, 1993). There is some evidence that bullying behaviors may decrease in high school (Newman, Holden, & Delville, 2005) and later in life (Olweus, 1993), although researchers have found that bullying can continue well into adulthood (Adams, 1992).

Research findings on the prevalence of bullying vary greatly depending on how bullying is defined (e.g., is teasing included as part of the definition?) and methodology of the study (Ross, 2002). For example, direct observation may not yield accurate information due to the covert nature of relational aggression (Olweus, 1993). Even given those differences, it is estimated that between 15% and 30% of students report being victims of bullying during their school years (Nansel et al., 2001; Newman et al., 2005; Olweus, 1993; Ross, 1996), and that 15% to 20% of students report bullying others on a regular basis (Melton et al. 1998; Nansel et al., 2001).

Research on cyberbullying is sparse, but some researchers have estimated that 19% of regular internet users between the ages of 10 and 17 have been involved in cyberbullying in some way (Ybarra & Mitchell, 2004). Cyberbullying has the potential to be more insidious than physical or relational bullying because it can occur 24 hours a day, can involve quick distribution of text or images to large audiences, and is harder to track due to the ability for it to be carried out anonymously (Willard, 2005).

Although bullying has become almost an expected part of being in school, being a bully, a victim, or both a bully and a victim (hereafter referred to as a bully/victim) may have serious implications for the involved student (Fried & Fried, 1996; Fleming &

Towey, 2002; Nansel, Overpeck, Haynie, Ruan, & Scheidt, 2003; National Education Association [NEA], 2003; Olweus, 1993). Students who bully others are more likely to fight frequently, be injured in a fight, steal, vandalize property, carry a weapon, drink alcohol, use drugs, smoke, and drop out of school (e.g. Cunningham, Henggeler, Limber, Melton, & Nation, 2000; Fleming & Towey; Nansel et al., 2001; Nansel et al., 2003; Olweus).

Long-term effects of bullying others are equally serious. In a 30 year longitudinal study, Eron and Huessman (1990) found that boys who bullied others when they were eight years old had a one in four chance of having a criminal record by age 30, as compared to the 1 in 20 chance of their non-bullying peers. Boys who bullied others at age eight also had higher incidence rates of committing serious crimes, lower social and professional achievement, higher rates of abusing their wives and children than their peers who had not bullied others (Eron & Huessman). These results were all independent of the IQ and socioeconomic status reported for the boys at age eight. Similarly, Olweus (1993) found that 60% of boys who bullied others in middle school had at least one criminal conviction by age 24 and that 40% had three or more criminal convictions by that age, rates three to four times higher than their non-bullying peers. Perhaps most importantly, boys who were bullying others at age eight were more likely to have children who also were identified as bullies (Eron & Huessman).

Being the victim of bullying behavior can have devastating effects. Although these effects are thought to be most severe during school years, there is evidence that consequences of being a frequent victim can carry into adulthood (Olweus, 1993; Ross,

1996). Bully victimization has been found to be related to lower self-esteem (Hodges & Perry, 1996; Olweus, 1978; Rigby & Slee, 1993), higher rates of depression (Craig, 1998; Fekkes, Pijpers, & Verloove-VanHorick, 2004; Hodges & Perry; Olweus, 1978; Rigby & Slee; Salmon, James, Cassidy, & Javoloyes, 2000; Slee, 1995), loneliness (Kochenderfer & Ladd, 1996; Nansel et al., 2001), and anxiety (Craig, 1998; Hodges & Perry, 1996; Olweus, 1978; Rigby & Slee, 1993). Also, researchers have found that students victimized by bullies experience physical and psychological ailments including headaches, abdominal pain, anxiety, unhappiness, and problems sleeping two to three times more frequently than their non-bullied peers (Fekkes et al., 2004). These students report severe depression as much as eight times more frequently than their non-bullied peers (Fekkes et al.) and report higher levels of suicidal ideation than their peers who are not bullied (Rigby). Bullying interferes with victims' academic work as well. As many as 160,000 students each day stay home from school due to fear of being bullied (Pollack, 1998), and victims have higher school absenteeism rates than those who aren't bullied (Rigby, 1996).

The third segment of students involved in bullying behaviors is the bully/victims. This category, which has also been called as *provocative victims* (Olweus, 1993) includes student who both bully and are victimized. This group of students frequently has the most difficulty, as they tend to report both the behavioral problems of bullies (e.g. theft, fighting, alcohol and drug use) and the psychosocial problems of victims (e.g. loneliness, depression, poor social relationships; Nansel et al., 2003). In a study of nearly 2,000 sixth grade students and their teachers in Los Angeles, students indicated that they avoided

their peers who were classified as bully/victims more than they avoided bullies, victims, or those uninvolved in bullying (Juvonen, Graham, and Schuster, 2003). Teachers rated the bully/victims as having more conduct problems and being more academically disengaged than the bully, victim, or uninvolved groups (Juvonen et al.).

In the past several years, incidents of school shootings (e.g. Columbine) have propelled a small segment of victims of bullying who retaliate with deadly violence into the spotlight. The Safe School Initiative Report was the result of research performed jointly by the U.S. Secret Service and the U.S. Department of Education on 41 attackers in the 37 incidents of targeted school violence that occurred between 1978 and 2000 (HRSA, 2005). Three quarters of the attackers had felt persecuted or bullied prior to their acts of violence (Vossekuil et al., 2002). Students surveyed on the causes of youth violence ranked harassment and/or lack of respect and need for acceptance and peer pressure as the top two peer factors contributing to youth violence (Zimmerman et al., 2004). Therefore, with the reported levels of prevalence in schools and the reported consequences of bullying and victimization, it is reasonable to assume that professional school counselors work with students who are involved in bullying and, in fact, that bullying constitutes a crisis in schools.

Gang Violence

Due to the fact that gang characteristics vary across the country, there is no accepted definition of youth gangs (Klein, 2002; National Youth Gang Center [NYGC], 2005; Weisel, 2002). For the purposes of this study, a youth gang will be defined as "a self-formed association of peers having the following characteristics: three of more

members, generally ages 12 to 24; a name and some sense of identity…; some degree of permanence and organization; and an elevated level of involvement in delinquent or criminal activity" (NYGC). In addition, the use of the term *gang* will be used interchangeably with the term *youth gang* throughout the remainder of this document.

Although there is no exact count of the number of gangs currently operating, the percentage of student reporting gang presence at their schools more than doubled in the six year period between 1989 and 1995 (Chandler et al., 1998), and over 90% of all cities with populations larger than 100,000 reported gang activity in 2002-2003 (Egley, 2005). Student reports vary somewhat from the estimations by law enforcement, but between 51% and 54% of students in cities with populations greater than 100,000 reported a gang presence in their schools and, even in the smallest communities, nearly a quarter of students reported that gangs were present in their schools (Howell & Lynch, 2000). Further, 7% of boys and 4% of girls in a nationwide sample reported being a member of a gang in the previous twelve months (Gottfredson & Gottfredson, 2001). As many as 30% of students may be a member of a gang in a 12 month period in areas where gangs are particularly active (Esbensen & Deschenes, 1998; Thornberry, 1998; Thornberry, Huizinga, & Loeber, 2004).

Youth gangs contribute to violence and crime problems in schools (Howell & Lynch, 2000). Students who report the presence of youth gangs in schools are over three times more likely to report knowing students who have brought a gun to school and are four times as likely to have reported seeing a student with a gun in school than students who do not report the presence of youth gangs in their school (Chandler et al., 1998). In

addition, the likelihood of violent victimization at school is increased by the presence of youth gangs (Chandler et al., Howell & Lynch). There is also a correlation between availability of multiple drugs in schools and presence of gangs in schools (Chandler et al., Howell & Lynch). The presence of gangs, therefore, has a demonstrated relationship with the presence of guns, drugs, and violence in schools around the country.

There are several reasons that adolescents typically report as reasons for gang involvement. Primarily, these reasons are for either social or protective reasons, with adolescents choosing to be members of a gang that already consists of their friends or family members or choosing a gang that they feel will provide them safety and protection from perceived threats (Decker & Van Winkle, 1996; Molidor, 1996; Peterson, Taylor, & Esbensen, 2004; Soriano, Soriano, & Jiminez, 1994; Thornberry, Krohn, Lizotte, Smith, & Tobin, 2003). The realities of gang involvement indicate, however, that adolescents who are members of gangs have a higher likelihood of being violently victimized than those who are not (Peterson et al.). Although gangs afford their members social connection with other delinquent peers, they limit prosocial activities and contacts (Thornberry et al., 2003; Thornberry et al., 2004). In addition, school achievement often is not a priority for gang members (Macmillan, 2001; Weist & Cooley-Quille, 2001), which could negatively affect the future career and educational opportunities of these students.

Gang presence in schools is related to increased reports of drug availability, presence of guns, and violent victimization of students (Chandler et al., 1998; Howell & Lynch, 2000), but the effects do not end there. Unaffiliated adolescents and young adults

who witness gang violence may report higher levels of depression, aggression, and symptoms of Post-Traumatic Stress Disorder (Fehon, Grilo, & Lipschitz, 2001; Scarpa, 2001; Slovak & Singer, 2001). Therefore, youth gangs constitute another area of concern for professional school counselors.

Child Abuse and Neglect

The physical abuse, sexual abuse, and neglect of children and adolescents are serious issues in the United States. Although definitions of what constitutes abuse and neglect vary, there are two standards used by the National Incidence Study of Child Abuse and Neglect (NIS) to define whether abuse and neglect have occurred: the *Harm Standard* and the *Endangerment Standard* (Sedlak & Broadhurst, 1996). The Harm Standard includes only those youth who have experienced demonstrable harm as the result of their abuse. The Endangerment Standard includes both those youth who have been harmed and those who were put at risk of harm. The NIS includes a series of studies that have been done six to eight years apart. The most recent NIS data is currently being collected, so the data presented in this paper is drawn from the most recently published iteration, the NIS-3 (Sedlak & Broadhurst) and supplemented by more recent data from the National Child Abuse and Neglect System. In the NIS-3, researchers collected data from a nationally representative sample of the Child Protective Services (CPS) agencies and community professionals in 42 counties who were working with abused youth and, therefore, includes children who may not have been reported to CPS (Sedlak & Broadhurst). The National Child Abuse and Neglect System (NCANS), on the other hand, includes only the reports of state CPS workers. In addition, the NCANS only

represents incidences of abuse or neglect by parents or primary caregivers (National Clearinghouse on Child Abuse and Neglect Information [NCCANI], 2004; 2005).

The estimated annual occurrences of child abuse and neglect range between 896,000 and 2,815,600 (NCCANI, 2004; 2005; Sedlak & Broadhurst, 1996). Because they do not include unreported or unknown cases of abuse and neglect, it is possible that even these high numbers are underestimates of the actual rates of child abuse and neglect in the United States. Of children and adolescents who are known to be abused or neglected, over 60% were neglected, nearly 20% were physically abused, and 10% were sexually abused (NCCANI, 2004; 2005). There was a marked increase in incidence rates reported between the NIS-2, published in 1988, and the NIS-3, published in 1996, with reported incidence rates 1.5 to 2.5 times higher and the numbers of children seriously injured increasing fourfold (Sedlak & Broadhurst). Whether this is a trend that will be continued or whether it marks a difference in mandated reporting laws remains to be seen. Even more startling is that the percentage of children and adolescents whose abuse or neglect was investigated by CPS declined during that same time period, from 44% of all youth who met the Harm Standard during the NIS-2 to 28% of all youth who met the Harm Standard during the NIS-3 (Sedlak & Broadhurst). Only 16% of youth who were reported by schools and met the Harm Standard were investigated by CPS (Sedlak & Broadhurst).

Educational personnel, including teachers, administrators, and school counselors, account for more referrals to child protective services than any other group of professionals or non-professionals (Crosson-Tower, 2003; Sedlak & Broadhurst, 1996). It

is striking, however, that less than one of every six youth reported by educational personnel was investigated by CPS. The reason for this discrepancy is unknown; however, it may be due to school personnel being unclear about the information that should be involved in making reports to CPS. In a study of child abuse reporting by school counselors, school counselors responded that they had seen between 0 to 50 cases (M = 5.16, SD = 5.65) of child abuse and/or neglect during the previous 12 months and had reported between 0 and 26 (M = 4.22, SD = 4.59) of those cases—just under 78% of suspected child abuse cases (Bryant & Milsom, 2005). Of the types of child abuse, school counselors reported being significantly more confident in their ability to recognize physical abuse than other forms of abuse (e.g., sexual abuse, emotional abuse, neglect; Bryant & Milsom). Because school counselors often are the individuals who follow up on suspicion of child abuse reported by teachers or who identify clusters of symptoms in children with whom they work, being prepared to identify and report abuse and offer appropriate intervention, referral, and/or follow-up services seems vital.

The results of child abuse and neglect can be fatal. During 2003, approximately 1,500 children and adolescents died as the result of abuse or neglect (NCCANI, 2005). For those youth who survive their maltreatment, there are serious emotional, physical, and social consequences (Germain & Sandoval, 2002). These may include anxiety and fear (Adams-Tucker, 1981), higher rates of delinquency and violent criminal activity in adolescence and adulthood for both males and females (Widom & Maxfield, 2001), mental health concerns (e.g. PTSD, depression, suicide attempts; Widom, 1999), intellectual and educational problems (Perez & Widom, 1994), prostitution (Widom &

Kuhns, 1996), and hypervigilance (NCCANI, 2003). Because of the physical, psychological, and emotional consequences of child abuse and neglect, it is vital that counselors know how to appropriately intervene and report child abuse.

Serious Mental Health Issues

An estimated 10% to 22% of school aged children face mental health issues severe enough to impair their functioning (National Advisory Mental Health Council, 1990; National Institute of Mental Health [NIMH], 2000). These mental health issues may include (but are not limited to) depressive disorders (e.g. major depressive disorder, dysthymic disorder, bipolar disorder), anxiety disorders (e.g. obsessive-compulsive disorder [OCD], generalized anxiety disorder, separation anxiety disorder, social phobia), autism, attention deficit and disruptive disorders (e.g. conduct disorder, attention deficit/hyperactivity disorder, oppositional defiant disorder), and eating disorders (e.g. anorexia nervosa, bulimia nervosa). A majority (70%-80%) of these children, however, do not receive mental health services (U.S. Department of Health and Human Services, 1999). When considering school-aged children and adolescents who do receive services, schools serve as the primary provider of children and adolescent mental health services (Burns et al.; 1995; Hoagwood & Erwin, 1997). In a study conducted in western North Carolina, Burns and her colleagues showed that schools provided the sole source of mental health services for over 70% of children and adolescents. In addition, schools provided the only mental health services for nearly half (46.5%) of students who had a diagnosed mental illness and impaired functioning (Burns et al.). In addition, due to the nature of cognitive and emotional issues, mental health problems may be less visible to

school counselors than suicidal, violent, or self-injurious behavior; however, mental health problems may be tied to these behaviors (NIMH, 2000). Therefore, it is vital that professional school counselors are able to identify and intervene with students who present with severe mental health issues.

School Counselors' Roles in Crisis Intervention

Approximately 95.2% of children ages 5-6, 98.3% of children ages 7-13, and 96.4% of children ages 14-17 were enrolled in school during 2002, percentages that have stayed relatively consistent since 1970 (National Center for Educational Statistics, 2003). Considering the prevalence of the crisis issues discussed above, the vast majority of students dealing with such crisis issues as suicide, SIB, violence, abuse, or other mental health issues will be enrolled in school while they are trying to deal with these issues. As the rates of students dealing with these issues have increased, school employees have had to find ways to help students with a variety of crisis-related problems (Bostic & Rauch, 1999). Consistent with this, Castro-Blanco (2000, p. 273) observed that "most crises involving children and adolescents either occur at school, are associated with school, or are first detected at school."

Several national organizations, including the American School Counselor Association [ASCA] and the Council for Accreditation of Counseling and Related Educational Programs (CACREP) include policies and standards that include professional school counselor knowledge and skill in prevention and crisis intervention strategies (ASCA, 2000a; CACREP, 2001). In addition to ASCA's position on school counselors serving as "pivotal members" of a crisis response team, the organization also

has articulated position statements about school counselors roles in development of bullying, harassment and violence prevention programs (ASCA, 2005), prevention of and intervention in cases of child abuse or neglect (ASCA, 2003), conflict resolution to reduce violence (ASCA, 2000b), and identifying and providing services to students-at-risk for suicide (ASCA, 1999). Both practicing school counselors and future school administrators also have rated crisis as a primary role and duty of school counselors (Ballard, 1995; Fitch et al., 2001). In fact, future school administrators rated direct crisis intervention response as the most important duty of school counselors (Fitch et al.).

Because school counselors are members of a school community who are expected to have knowledge of mental health issues, they have central roles on school crisis teams, both in development of crisis intervention strategies and in implementation of crisis plans after crises occur (ASCA, 2000; Gallagher & Coy, 1998; Petersen & Straub, 1992). This role may be as a crisis coordinator who directs crisis intervention activities, referral, counseling or other activities with students and staff after a crisis has occurred (ASCA; Brock, Sandoval, & Lewis, 1996).

School Counselors' Training in Crisis Intervention

National organizations, accrediting bodies, practicing school counselors, and future school administrators have all stated that school counselors have a primary role and responsibility in school crisis situations (ASCA, 2000; Ballard, 1995; CACREP, 2001; Fitch et al., 2001; Peterson & Straub, 1992). Other researchers have called for school counselors to have specific skills training in crisis intervention (Greenstone & Leviton, 2002; Johnson, 2000; Myer, 2001; Pitcher & Poland, 1992; Schonfeld &

Newgass, 2000) due to the fact that training in counseling and other helping skills alone is not sufficient for the management of crisis (Greenstone & Leviton) and that successful crisis intervention requires specific assessment skills and an understanding of how to work in unpredictable circumstances (James and Gilliland, 2001). Crisis intervention seems to be relegated by some to training that finally occurs on the job (Myer). By the time school counseling students graduate, however, as many as 70% already have encountered a situation requiring crisis intervention in either their practicum or internship (Allen et al., 2002). Of those school counselors studied, only 54% reported they had "adequate" supervision of practicum or internship crisis intervention experiences (Allen et al.). The literature demonstrates overwhelming support for providing both future school counselors and practicing school counselors with crisis intervention training.

Even given such strong support and recommendation, researchers have demonstrated that school counselors feel less than adequately trained in crisis intervention (Allen et al., 2002). For example, in a study by Allen and her colleagues, 56% of school counselors reported being "not at all" or "minimally" prepared to intervene in a crisis situation, and over 35% of school counselors reported that they received no training at all in crisis intervention during their graduate education. Similarly, other researchers (King, Price, Telljohann, & Wahl, 1999) found that only 38% of school counselors believed they could recognize a student at risk for suicide. Even school counselors who report prior training in crisis intervention have stated that they want additional training (Mathai, 2002). Many school counselors have reported the need for a specific university course on crisis intervention (Allen et al.)

One potential reason that crisis intervention training may be lagging behind is that there is limited research on what to teach and how to prepare others for crisis intervention (Barrio, Wachter, & Shoffner, 2005). A review of the literature failed to find even a single article on how to train school counselors in crisis intervention (Barrio et al., 2005). Another factor that might be impacting preparation for crisis and crisis intervention skills in the schools is that handling crisis and its aftermath is neither a primary mission of schools (Schonfeld & Newgass, 2000) or one of the three stated domains (i.e., academic, career, and personal/social) of the ASCA National Model for School Counselors (ASCA, 2003). Although crisis intervention is a portion of the *Responsive Services* that those adhering to the National Model are expected to implement, crisis intervention does not appear on the model itself (ASCA). Crisis intervention training, however, has been reported as vital in preventing confusion after crisis, increasing overall respect for school leadership, and promptly addressing the needs and concerns of those directly and indirectly impacted by the crisis (Schonfeld & Newgass).

Burnout

Burnout, a descriptor for staff who are exhausted, detached, cynical, and lack motivation was first mentioned by Freudenburger (1974) in his article describing the phenomenon in the drug abuse recovery setting where he worked and has been defined in the literature as "a syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment" (Maslach, 1982, p. 3). Although burnout has been studied in multiple realms, including business (Cahoon & Rowney, 1984; Levinson, 1981), athletics (Capel, Sisley, & Desertrain, 1987; Dale & Weinberg, 1990), parenting (Pelsma, Roland,

Tollefson, & Wigington, 1989), and marriage (Pines, 1988), it is typically associated with those in helping fields (Schaufeli, Maslach, & Marek, 1993). Predominantly, burnout is believed to be a response to the emotional exhaustion that comes from working with those who are troubled (Edelwich & Brodsky, 1980; Maslach; Maslach, Schaufeli, & Leiter, 2001). Because burnout involves "physical and emotional exhaustion … the development of negative self-concept, negative job attitude, and loss of concern and feeling for clients" (Pines & Maslach, 1978, p. 234), it can contribute to counselor impairment (Maslach, 1986). In the following sections, Burnout Theory will be described, the relationship between exposure to crisis situations and burnout will be detailed, and research on burnout and school counselors will be explored.

Burnout Theory

Burnout is described as having three distinct components: emotional exhaustion, depersonalization, and reduced personal achievement (Maslach, 1993; 2003; Maslach & Jackson, 1981; 1984). Because researchers have shown that human services professionals, including counselors, are at higher risk of burnout than individuals in other occupations (DeVoe, Spicuzza, & Baskind, 1983; Edelwich & Brodsky, 1980; Freudenberger, 1975; Gold, 1983; Iwanicki & Schwab, 1981; Maslach, 1976; Maslach & Jackson, 1981; Pines, Aronson, & Kafry, 1981; Riggar, 1985) and this paper focuses on counselors, specifically school counselors, the components of burnout will be described in terms of how they may manifest with counselors.

When faced with the often-constant demands of time and energy from clients and institutions, counselors can become overloaded, their stress levels increase, and they may

become depleted of their physical and emotional resources and lack a way to recharge or refuel themselves, reaching a state of *emotional exhaustion* (Maslach, 1982; 1993). In this state, they may feel that they cannot give any more of themselves to others and employ behaviors meant to provide cognitive and emotional distance from their jobs and their clients, including stereotyping and categorizing their clients, so that they can react to that category of client, rather than the client her or himself (Maslach, 1982). When counselors distance themselves due to emotional exhaustion, this may lead to *depersonalization.* Depersonalization occurs when counselors become emotionally distant and detach themselves from clients and become cynical and callous in counselor-client interactions (Maslach, 1982). One phrase that continuously appears in quotations from professionals describing their reactions to depersonalization was that they "just don't give a damn anymore" (e.g. Maslach, 1982). When helping professionals reach the stage of depersonalization, they can feel inadequate and guilty that they have failed to serve their clients and begin to feel *reduced personal accomplishment* (Maslach, 1982). Reduced personal accomplishment is described as inefficacy or inadequacy in performing specific job functions (Maslach, 2003). Although reduced personal accomplishment may be a further effect of emotional exhaustion and depersonalization, it has been primarily reported as the result of lacking necessary resources to complete job tasks (Maslach, 2003; Maslach, Schaufeli, & Leiter).

Consequences of Burnout

Burnout has serious repercussions for counselors, students, and the school and community at large (Maslach, 1982). Intrapersonal consequences of burnout for the

counselor may include physical exhaustion, difficulty sleeping, feeling run down, tension and pain, nightmares, higher susceptibility to illness, psychosomatic complaints, substance abuse, reduced self-esteem and personal accomplishment, self-blame, isolative behavior, depression, anxiety, irritability, restlessness, suspicion, and paranoia (e.g. Cherniss, 1980; Edelwich & Brodsky, 1980; Freudenberger, 1974; Maslach).

Often, those in helping relationships who suffer from burnout find themselves frustrated and may, in turn, take out those feelings of frustration and emotional exhaustion on clients (Edelwich & Brodsky, 1980). Counselors who are burned out may lack motivation and have increased levels of frustration, working with minimal or no effort or emotional engagement and detaching themselves psychologically and emotionally from the individuals they serve, often labeling them and treating them as dehumanized objects (Maslach, 1982). In addition to distancing themselves from clients, counselors who are struggling with depersonalization may lose their ability to empathize with clients (Emerson & Markos, 1996; Skovholt, 2001). Because empathy is a core therapeutic condition (Rogers, 1980), counselors who experiencing burnout may be unable to provide effective services and, in some cases may be harmful, negative, and cynical towards their clients (Maslach; Maslach, Schaufeli, & Leiter, 2001). The triad of emotional exhaustion, depersonalization, and reduced personal accomplishment may manifest in ways that rob counselors of their ability to see each client as an individual with strengths and weaknesses (Maslach, Schaufeli, & Leiter).

As burnout progresses, an affected counselor may withdraw or detach from the job itself through use of sick leave and vacation days, chronic absenteeism, rigidity and

refusal to perform certain tasks, quitting her or his job, and, sometimes, leaving the profession (Maslach, 1982). Low job satisfaction, provision of services that are compromised, and high rates of job turnover are all subsequent effects of burnout in the helping fields (Edelwich & Brodsky, 1980; Maslach, Schaufeli, & Leiter, 2001). Therefore, burnout damages not only the individual professionals who are affected by it, but also their relationships with clients, the institutions where they are employed, and the profession they have chosen.

Burnout and Crisis

Frequent exposure to client pain and crisis has been cited as a risk factor for burnout in helping professions (Ackerley, Burnell, Holder, & Kurdek, 1988; Fischbach, 1990; Freudenberger & Richelson, 1980; Foss, 2002; Fong, 2005; Kottler, 1986; Maslach, 1976; Maslach & Jackson, 1981; Pines & Aronson, 1988; Schaufeli, Marek, & Maslach, 1993). In her dissertation on burnout in residential caregivers of emotionally disturbed children, Fong noted that there was a significant positive relationship between crisis contact hours and reported levels of emotional exhaustion. Similarly, Foss noted that levels of emotional exhaustion are significantly positively correlated with exposure to crisis in mental health professionals, and Fischbach (1990) reported that crisis counselors reported higher levels of burnout than general practice counselors reported. In a small study of psychology trainees working in a crisis setting, 100% of the trainees reported elevated burnout levels at some point during the six-month study, with half reporting increasing levels of burnout throughout the six months and the other half reporting a peak in burnout levels after three months and decreasing levels of burnout

thereafter (Von Baeyer, 1988). This finding may indicate that training and development of coping resources may help reduce burnout (Von Baeyer).

Burnout and School Counselors

Although any individual in a helping relationship may be at risk for burnout, it may be argued that those who are consistently working with individuals who are in a crisis state are at higher risk. School counselors may experience a high frequency of exposure to crisis and be expected to play an active role in crisis intervention (Allen et al., 2001; ASCA, 2000; Fitch et al., 2001; Mathai, 2002). In a review of the literature, however, no references were found that detailed the effects that crisis and crisis intervention in the schools might have on professional school counselor burnout. Therefore, the following section will discuss burnout among professional school counselors.

The roles and foci of school counselors have changed dramatically in the past 40 years, from working to prevent dropouts in the 60's; to a career counseling role in the 70's; to substance abuse, a skyrocketing divorce rate, and increased suicide rates in the 80's; to school violence in the 90's (Johnson & Johnson, 2003). As the roles have shifted, school counselors have found themselves with larger caseloads of students with more severe problems (Johnson & Johnson). At the same time, there has been a push towards accountability and high stakes testing, which also often falls within the work domain of school counselors.

Considering all these factors, it is not surprising that school counselors report being overwhelmed (Emerson & Markos, 1996). In fact, several researchers have noted

that school counselors may be at high risk for burnout (Bacharach, Baucer, & Conley, 1983; Crutchfield & Borders, 1997; Kesler, 1990; Lambie, 2002). Recently, Stephan (2005) found 66% of middle school counselors in a statewide sample reported moderate to high levels of emotional exhaustion and 77% reported a moderate to high level of depersonalization. Another study by Crutchfield and Borders (1997) demonstrated a level of empathy in school counselors low enough to be labeled "subtractive" (p. 224). These studies, though few in nature, may suggest a population of school counselors in need of attention and intervention in order to protect them from burnout.

A thorough review of the literature revealed no articles on the link between crises in the schools and school counselor burnout. With the evidence that exposure to crisis situations is related to burnout (Ackerley, Burnell, Holder, & Kurdek, 1988; Freudenberger & Richelson, 1980; Foss, 2002; Fong, 2005; Kottler, 1986; Maslach, 1976; Maslach & Jackson, 1981; Pines & Aronson, 1988; Schaufeli, Marek, & Maslach, 1993), and that school counselors are expected and directed to intervene in crisis situations (ASCA, 2000; Ballard, 1995; CACREP, 2001; Fitch et al., 2001; Peterson & Straub, 1992), an examination of school counselor exposure to crisis, school counselor crisis intervention training, and school counselor burnout is warranted.

Conclusion

In this chapter, the literature of crisis as a theoretical construct was outlined. Crisis in the schools, with particular focus on the prevalence and consequences of suicide, self-injurious behavior, school violence, bullying, gang violence, child abuse and neglect, and serious mental health issues, was detailed, and school counselors' roles in

crisis intervention was discussed. In addition, the literature on burnout theory, the consequences of burnout, the relationship between burnout and crisis work, and burnout in school counselors was reviewed.

CHAPTER III

METHODOLOGY

A review of the literature regarding crisis interventions in the schools was provided in chapter two. The need for information about preparation for crisis intervention of school counselors and how crisis frequency and lack of preparation may influence school counselor burnout was emphasized. In this chapter, research hypotheses are provided, participants are described, and instrumentation is defined. The purpose, procedures, and results of a two-stage pilot study to develop and test instrumentation is detailed, and the procedures, data analyses, and limitations of the current study are reviewed.

Research Questions and Hypotheses

Nine major research questions were discussed in chapter one. In the following section, hypotheses were formulated to test those research questions.

Research Question 1

What individual crises do school counselors encounter?

Hypothesis 1

Professional school counselors will describe a variety of individual crises that they encounter during the school year, including suicidal ideation, suicidal behavior, self-injurious behavior, homicidality/violence, physical abuse, sexual abuse and, on occasion, severe psychiatric problems (Mathai, 2002).

Research Question 2

With what frequency does each of the individual crises occur?

Hypothesis 2

Suicidal ideation and child physical abuse will occur most frequently, with child sexual abuse, suicidal behavior, homicidality, and completed suicide occurring less frequently (Mathai, 2002).

Research Question 3

What training/preparation do school counselors have in crisis intervention?

Hypothesis 3

Professional school counselors will report a variety of crisis intervention training experiences, including graduate level courses, coursework integrated into other courses, workshops, and in-service training experiences (Allen et al., 2002; Mathai, 2002). In addition, some counselors will report having no crisis intervention training (Allen et al.; Mathai).

Research Question 4

How helpful do school counselors perceive their crisis intervention training to be?

Hypothesis 4

In accordance with the literature, school counselors will, on average, perceive that their crisis intervention training is inadequate to address the frequency and severity of individual crises in their school (Allen et al., 2002).

Research Question 5a

What resources do school counselors use when faced with individual crises?

Hypothesis 5a

School counselors will utilize a variety of resources, but will rely primarily on on-site personnel (e.g. other school counselors, administrators) or the district crisis team.

Research Question 5b

How useful do school counselors perceive their crisis resources are?

Hypothesis 5b

Due to the exploratory nature of this question and the lack of existing literature related to this issue, there is no hypothesis.

Research Question 6

What crisis intervention skills do school counselors identify as most important?

Hypothesis 6

Mathai's study included a list of requested crisis training topics including responding to violence, psychological first aid, critical incident stress debriefing, legal/ethical issues, PTSD, assessment and referral, age-specific responses to trauma, suicidal ideation lethality assessment, suicide prevention/intervention, children's grief reactions, and stages of grief. Based on these previous findings, it is anticipated that professional school counselors will identify skills including violence assessment, suicide assessment, ethical decision-making, and critical incident stress debriefing as most important.

Research Question 7

How do training/preparation, resources, skills, and levels of burnout vary based on individual (i.e., years of counseling experience, teaching background, demographic

variables) and school characteristics (i.e., grade level, socioeconomic composition, number of counselors at the school)?

Hypothesis 7

There will be no mean difference in training/preparation, resources, skills or levels of burnout among counselors with different individual or school characteristics and/or demographics.

Research Question 8a

To what extent do frequency and exposure to individual crises predict school counselor burnout?

Hypothesis 8a

Because high rates of individual crisis have been associated with burnout (Collins & Collins, 2005), it is anticipated that professional school counselors who report higher crisis incidence rates will report higher levels of burnout.

Research Question 8b

What are the better predictors of school counselor burnout?

Hypothesis 8b

It is anticipated that crises will predict school counselor burnout equally.

Research Question 9

When taken in combination with crisis frequency and crisis exposure, how well does level of training predict different burnout levels than crisis frequency and exposure alone?

Hypothesis 9

It is hypothesized that self-perceived training in crisis intervention will moderate the relationship between crisis frequency and severity and professional school counselor burnout. Specifically, it is hypothesized that reported frequency of and exposure to crisis will have less effect on school counselor burnout for those school counselors who report higher levels of crisis intervention training.

In addition to the data being collected for the above research questions, other data is being collected for heuristic purposes, including the perceived level of importance and changeability of the selected crises, topics covered in master's and post-master's crisis coursework, demographic information about participant education (e.g., year of graduation, specific degree title), and demographic information about the school in which the participant is employed (e.g., school district), in order to more fully explore and understand the data collected in this dissertation study.

Population and Participants

The population of interest for this study included practicing professional school counselors employed in schools ranging from grades kindergarten through 12th grade. In order to be eligible to participate in this study, participants must have fulfilled the following requirements: (a) self-identify as professional school counselors, (b) have completed at least a master's degree in counseling, and (c) be employed currently as a school counselor. A target sample size of 159 professional school counselors was set based on a power analysis for the planned data analyses. This sample size would allow adequate power (0.80) to identify a moderate effect size. In order to reach potential

participants, the researcher contacted the Department of Public Instruction of North Carolina to obtain a statewide list of current professional school counselors. From this list, 275 school counselors were randomly selected from each level (i.e., elementary, middle/junior high, and high school), for a total pool of 825 school counselors. The final sample included 132 participants who met criteria for the study, yielding a final response rate of 16%.

Instrumentation

The following instruments were used in this study: the Crisis Intervention Descriptive Questionnaire (CIDQ; Wachter, 2006), the Burnout Measure: Short Version (BMS; Malach-Pines, 2005), a researcher-created demographic questionnaire, and a contact sheet (Stephan, 2005). All instruments were self-report. The individual assessments are described in detail below, including the purpose and psychometric properties of each. Following these descriptions, the pilot study used to develop the CIDQ will be described.

Crisis Intervention Descriptive Questionnaire (CIDQ)

After a thorough review of the literature, no existing instrumentation was identified that adequately addressed not only the types and frequencies of crises in the schools, but also formal and informal crisis intervention training, use of resources during crisis intervention, perceived adequacy of crisis intervention training and resources, and skills vital to effective crisis intervention training. Therefore, the CIDQ was developed by the researcher to measure these constructs as reported by practicing professional school counselors. The CIDQ consists of 43 items, both quantitative and qualitative in nature,

and six scales. The first scale, *crisis exposure,* was scored from 0-12 based on the first item, where participants marked "yes" or "no" to whether they had been exposed to 12 types of individual crisis. The second scale, *crisis frequency,* was the sum of times the participant has encountered those crises over the past 12 months (i.e., a participant who has seen five instances of suicidal ideation, three instances of child neglect, and two instances of self-injury, and has not seen any of the other crises received a score of 10). The third scale, *training,* was a sum of the presence or absence of training (e.g., workshops, presentations, coursework, etc.) on specific crisis topics during both master's and post-master's training experiences. The training scale consists of two sections, *master's training* and *post-master's training*, both of which were scored the same way. For example, a participant who had received training in suicidality during her or his master's program, and training in CISD, severe mental health issues, and child abuse and neglect would be given a total training score of 4, a master's training score of 1, and a post-master's training score of 3. The fourth scale, *resource helpfulness* consisted of 3 items for which participants rate how helpful a series of physical resources, in-house personnel resources, and external personnel resources were to the crisis intervention process. These resources were rated on a four-point scale (1 = not helpful, 4 = very helpful). The fifth scale, *necessary skills* consisted of 64 skills that participants rated on a four-point rating system (1 = unnecessary, 4 = vital). The sixth scale, *skills comfort,* consisted of participant ratings of comfort level performing the same series of 64 skills on a four-point rating system (1 = not at all comfortable, 4 = very comfortable). Further

information about the development of the CIDQ can be found in the description of the pilot study.

Burnout Measure: Short Version (BMS; Malach-Pines, 2005)

The Burnout Measure, Short Version (BMS; Malach-Pines, 2005) is a 10 item self-report assessment that was developed based on demands for a brief, user-friendly measure that could be used for research purposes. The BMS was adapted from the Burnout Measure (Pines & Aronson, 1988), a 21-item self-report assessment. Like the Burnout Measure, users respond to the BMS on a 7-point Likert-type scale (1 = never, 7 = always) to describe how frequently respondents report physical (e.g. weak/sickly), mental (e.g., disappointed with people), and emotional exhaustion (e.g., hopeless).

The BMS has been tested on three occupational samples (police officers, nurses, and MBA students) and two national samples (Jewish-Israeli and Arab-Israeli) (Malach-Pines, 2005). Internal consistencies ranged from 0.85-0.92, providing strong evidence for internal consistency reliability. Three-month test-retest reliability was reported at 0.74, indicating a moderate level of stability over time. Evidence of moderate temporal stability seems acceptable given the lability of the burnout construct. In addition, the construct validity of the BMS has been demonstrated through correlations with other related variables, including negative correlations with life satisfaction (-0.35) and general optimism (-0.39), and positive correlations with somatic complaints (0.66) and general level of stress at work (0.51). Therefore, the BMS has evidence of internal consistency, temporal stability, and construct validity.

Demographic Questionnaire

Participants also completed an 17-item demographic questionnaire developed for this study. In this questionnaire, participants were asked to provide information regarding personal characteristics (e.g., sex, age, ethnicity), professional characteristics (e.g., degree status, former teaching experience, licensure status, years of school counseling experience), characteristics of their schools (e.g., size, grade level, ethnic/racial composition, socioeconomic composition, number of counselors on staff) and characteristics of their training program (e.g., CACREP accredited).

Contact Sheet

The contact sheet (Stephan, 2005) is a six-item instrument; participants provide their name, address, phone number, and e-mail address. In addition, participants were asked to indicate whether they would like a summary of research findings and if they would be willing to be contacted in the future as a follow-up. All contact sheets were coded and then immediately separated from returned packets and maintained in a separate file in order to preserve the anonymity of respondents.

Pilot Study: Initial Development of the CIDQ

Crocker and Algina (1986) recommended a ten step process to construct and test a valid instrument. Specifically, the authors addressed the need to (1) identify the primary purpose of the instrument, (2) identify behaviors to represent the construct, (3) prepare a set of test specifications, (4) construct an initial item pool, (5) review and revise items, (6) hold preliminary item tryouts, (7) field-test the items, (8) determine statistical properties of items, (9) conduct reliability and validity studies, and (10) develop

guidelines for administration, scoring, and interpretation. These steps were followed in the development of the CIDQ and are elaborated on in the following paragraphs.

Step 1: Identification of primary purpose. The purpose of the CIDQ was to measure counselors' levels of exposure to different crisis events, to assess the type and perceived adequacy of crisis intervention training received and resources used during crisis intervention, and to identify the crisis intervention skills that professional school counselors think are fundamental to effective crisis intervention.

Step 2: Identification of behaviors to represent the construct. Crocker and Algina (1986) suggested that researchers use at least one of the following methods to identify behaviors that represent the construct: content analysis, review of research, critical incidents, direct observation, expert judgment, or instruction objectives. After a review of available research to determine types of crises, anticipated types of crisis intervention training and crisis intervention resources used, and critical crisis intervention skills, expert judgment was solicited from school counselors, crisis workers, and school counselor educators in order to collect information about specific questions and criteria that should be used to best measure these constructs.

Step 3: Test specifications. It was determined by the researcher that each construct measured had equal importance, and, therefore should be equally represented on the instrument.

Step 4: Construction of initial item pool. Items were written based on the crisis theory literature and crisis intervention literature as well as on the expert judgment of

crisis assessment counselors and school counselor educators. Questions were formatted for ease of use and to encourage variability of response.

Step 5: Item review and revision. Upon construction of the items, an initial form of the CIDQ was drafted and presented to an expert panel, including experts in survey construction, crisis, and school counselor education in order to determine accuracy and relevance to test specifications, identify item-construction errors and bias, and identify questions that might need to be clarified.

Step 6: Preliminary item tryouts. After the items were reviewed by experts and revised, it was presented to a small focus group consisting of a school counselor educator, a practicing school counselor, and a crisis intervention expert in order to ensure the readability, ease of response, and appropriate amounts of variability for the larger pilot study sample. The cover letter and informed consent to participate in the focus group may be found in Appendix A.

Steps 7-10: Additional steps. After preliminary item tryouts, Crocker and Algina (1986) recommended completing a field test of the instrumentation, calculating statistical properties of items, completion of reliability and validity studies, and developing specific guidelines for administration, scoring, and interpretation. Specific details about these steps are included in the following section, including means and frequencies of items, item analyses, initial reviews of reliability and validity which were completed after field testing.

Pilot Study Phase 2: Field Testing

A two-phase pilot study was conducted to assess the proposed procedures and instrumentation for the primary study. In the following section, the specific purposes of the second phase of the pilot study are discussed, including the definition of instrumentation and participants, and a detailed discussion of the procedures. Data analysis, results, and discussion of necessary modifications of instrumentation and procedures for the main study are then discussed.

Purpose of the Study

The purpose of the pilot study was two-fold. First, it was to field test the CIDQ, an assessment constructed for this study, to ensure readability and utility. Second, it was to explore the validity and reliability of the survey packet and test the procedures for the major study.

Instrumentation

Instrumentation utilized in the pilot study included the Crisis Intervention Descriptive Questionnaire (CIDQ), Burnout Measure: Short Version (BMS), and a demographic questionnaire. These instruments were discussed earlier in this chapter. In addition, participants were asked to complete a six-item, open-ended evaluation regarding the ease of use, clarity of instructions, clarity of items, and time taken to complete the procedures (Appendix B). The process was projected to take approximately thirty (30) minutes.

Participants

Pilot study participants included a convenience sample of 10 practicing school counselors. To recruit participants, the researcher distributed packets containing a cover letter with a description of the study and information about informed consent, a survey packet, and a contact sheet. Of the 10 packets distributed, eight were returned. Of the eight returned, one did not meet eligibility requirements, due to a change in position from school counselor to "student services personnel," leaving a final response rate of 70%.

Procedures

Prior to data collection, the proposed procedures and instrumentation were reviewed by the Human Subjects Review Board at the University of North Carolina at Greensboro (Appendix D). Participants were then invited to participate in the study via receipt of an instrumentation packet including a cover letter with an invitation to participate and informed consent, a contact sheet, and a questionnaire packet. As an incentive for participating, individuals were informed that, upon completion of the questionnaire, they could return a contact sheet to enter their name in a drawing for one of two $50 cash incentives.

Data Analysis

Analyses of pilot study data included examination of participant demographics, review of instrument descriptives and item analyses of the skills segment of the CIDQ. A summary of these analyses is presented in Table 1. All data were computer analyzed using SPSS 14.0 (SPSS, Inc., 2005).

Table 1

Data Analysis Procedures for Pilot Study

	Descriptive Statistics	*Item Analysis*
Hypothesis 1	X	
Hypothesis 2	X	
Hypothesis 3	X	
Hypothesis 4	X	
Hypothesis 5	X	
Hypothesis 6	X	
Hypothesis 7	X	X
Hypothesis 8	X	
Hypothesis 9	X	
Hypothesis 10	X	

Results

Participant Demographics

Of the seven participants who completed the questionnaire, 85.7% (n = 6) were female and 71.4% (n = 5) were Caucasian. Participants ranged in age from 25 years to 52 years (M = 35.14, SD = 11.50) and reported between 0.0 and 25 years of counseling experience (M = 6.86, SD = 9.06). Every participant had completed at least a masters degree and 42.9% (n = 3) had completed an educational specialist degree. Nearly all participants (85.7%; n = 6) had received their master's degree in school counseling, and only two (29.6%) had prior teaching experience. Just under half (42.9%) were Nationally Certified Counselors, and none (0%) were Licensed Professional Counselors. A summary of demographic information regarding pilot study participants is included in Table 2.

Table 2

Selected Demographics of Pilot Study Participants

Demographic Characteristic	*n*	*%*	*Demographic Characteristic*	*n*	*%*
GENDER			MEMBERSHIP		
Female	6	85.7	ACA	1	14.3
Male	1	14.3	ASCA	2	28.6
Total	7	100.0	ACES	0	0.0
			NCCA	1	14.3
ETHNICITY			NCSCA	4	57.1
Caucasian	5	71.4			
African-American	2	28.6	LICENSE/CERTIFICATION		
Total	7	100.0	LPC	0	0.0
			NCC	3	42.9
DEGREE STATUS			NCSC	0	0.0
MS only	4	57.1			
Masters/EdS	3	42.9	TEACHING EXPERIENCE		
Total	7	100.0	Yes	2	28.6
			No	5	71.4
MASTER'S IS IN:					
School	6	85.7	GRADES SERVED		
Community	1	14.3	9-12	6	85.7
Total	7	100.0	PK-2	1	14.3

Instrument Descriptives and Reliabilities

Descriptive statistics (e.g., means, standard deviations, ranges of scores) and internal consistency reliabilities were computed for the skills, skills necessity, skills comfort, crisis exposure, and crisis frequency scales. This information is presented in Table 3 along with possible minimum and maximum scores for each instrument and scale. Internal consistency reliabilities were acceptable for all subscales of the CIDQ (0.72-0.97), but were lower for the crisis exposure and crisis frequency scales (0.74 and 0.72, respectively). The current evidence of the internal consistency reliability for the BMS was consistent with the reliability reported in the literature ($\alpha = 0.87$). The obtained range of scores was somewhat constricted on the skill comfort subscale, with a range of

30 (out of a possible 212), and the mean scores for the skills necessity and skills comfort subscales were negatively skewed (M = 247.60 and M = 214.60, respectively).

Table 3

Pilot Study Instrument Descriptives and Reliabilities

Scale	*Subscale*	α	M	SD	*Scale Min*	*Scale Max*	*Pilot Min*	*Pilot Max*
CIDQ	Crisis Exposure	.736	10.0	2.28	0	13	7	12
CIDQ	Crisis Frequency	.720	47.67	28.50	0	--	10	93
CIDQ	Skill Necessity	.971	247.69	26.05	72	288	200	285
CIDQ	Skill Comfort	.927	214.80	11.80	72	288	205	235
BMS		.870	19.86	6.04	10	70	10	30

Pilot Study Results and Psychometrics

School counselors reported seeing a variety of individual crises over both their tenure as school counselors and over the past 24 months. Of the 13 types of crises listed, participants had been exposed to a majority (M = 10, SD = 2.28). In addition, many participants reported having seen multiple incidences of crisis over the past 24 months (M = 47.67, SD = 28.50). The exposure to specific types of crisis and descriptive statistics about the frequency of exposure to those types of crises can be found on Table 4.

Participants reported having limited exposure to crisis intervention training. None of the participants had taken a crisis intervention course either during or after their master's program, and only one remarked that a course on crisis had been available. For detailed description of exposure to training on specific crisis topics both during the

completion of a Master's program and after completion of a Master's program, see Table 5.

Table 4

Exposure to Crisis and Crisis Frequency

Crisis Type	*Percent Exposed*	M	SD	*Pilot Min*	*Pilot Max*
Physical Abuse	85.7%	9.57	17.95	0	50
Relational Aggression/Bullying	85.7%	8.83	8.70	0	20
Severe Mental Health Issues	100%	6.43	4.58	2	15
Physical Aggression/Bullying	100%	6.29	3.50	3	10
Other School Violence	71.4%	6.14	9.49	0	20
Neglect	100%	4.71	6.85	0	20
Self-Injurious Behavior	85.7%	3.71	5.28	0	15
Suicidal Ideation	85.7%	3.43	3.60	0	10
Suicidal Intent	85.7%	1.57	1.13	0	3
Sexual Abuse	85.7%	1.57	0.98	0	3
Suicidal Behavior	71.4%	1.42	1.51	0	4
Gang Violence	57.1%	0.57	0.79	0	2
Homicidal Intent	0%	0	0	0	0

Table 5

Crisis Training by Topic During and After Master's Program

Crisis Topic	*Received Any Type of Training*	
	Master's Program	Post Master's Program
Suicidal Behavior and Ideation	100%	57.1%
Child Abuse and Neglect	85.7%	71.4%
Gang and School Violence	57.1%	71.4%
Severe Mental Health Issues	57.1%	57.1%
Bullying	42.9%	85.1%
Self-Injurious Behavior	42.9%	28.6%

When asked about resources they turn to during crisis situations, participants appeared to utilize a variety of physical resources, in-house personnel, and external personnel. For a listing of resources used and the perceived helpfulness of those resources, please refer to Table 6.

Table 6

Perceived Helpfulness of Resources

Resource	Perceived Helpfulness			
	M	*SD*	Pilot Min.	Pilot Max.
Other On-Site School Counselors	4.00	.00	4.00	4.00
School Social Worker	4.00	.00	4.00	4.00
School Psychologist	3.50	.55	3.00	4.00
Crisis Manuals	3.43	.98	2.00	4.00
Psychologists	3.40	.89	2.00	4.00
Community Counselors	3.33	1.03	2.00	4.00
Psychiatrists	3.25	.96	2.00	4.00
District Crisis Plan	3.00	1.10	2.00	4.00
Assistant Principals	3.00	1.29	1.00	4.00
Principal	3.00	1.26	1.00	4.00
Exceptional Children Teacher	3.00	1.00	1.00	4.00
School Counselors at Other Schools	3.00	.89	2.00	4.00
Crisis or Information Hotlines	3.00	.71	2.00	4.00
Internet	2.83	.98	2.00	4.00
Director of Student Services	2.83	1.47	1.00	4.00
Police	2.75	.96	2.00	4.00
Journal Articles	2.71	.49	2.00	3.00
School Counselor Educators	2.60	1.14	1.00	4.00
Teacher	2.50	1.05	1.00	4.00
Central Office	2.50	1.38	1.00	4.00
School Nurse	2.43	.79	1.00	3.00
Magistrate	2.33	1.15	1.00	3.00
School Resource Officer	2.17	.98	1.00	3.00
Textbooks	2.14	.69	1.00	3.00

Participants in the pilot study seemed to consider most of the skills important (M = 3.44; SD = 0.36), but there were five that were rated as "Vital" by all participants. These skills were a) Provide support to the student; b) Actively listen to the student; c) Implement school crisis plan in instances of suicide, suicidal behavior, and/or suicidal ideation; d) Implement school crisis plan in instances of child abuse or neglect; and e) Initiate contact with parents of student(s) in crisis. For a complete list of participants' ratings of the necessity of all identified skills and their self-perceived comfort levels with those skills, please refer to Appendix C.

Due to a limited demographic variability in the pilot study participants, analyses of group differences in training/preparation, resources used, and skills identified were not run on the pilot study sample. These analyses will be run on the larger sample available in the full study.

Due to the small sample size and limited diversity in training experiences of the participants, no advanced statistics were run to look at potential moderating relationships that training might have between crisis frequency and severity and professional school counselor burnout. This analysis will be run on the larger sample obtained in the full study.

Discussion

The main purposes of the pilot study were to field test the CIDQ, an assessment constructed for this study, to ensure readability and utility, to explore the validity and reliability of the survey packet, and to test the procedures for the major study. Based on feedback from participants, several typographical errors were corrected. Given that two

participants did not complete the instrumentation and that several participants commented on the page-length of the questionnaire, participant response rates arose as a primary concern in the pilot study. In attempts to reduce this concern, several items that seemed repetitive were condensed, and the training segment of the CIDQ was reformatted to condense the information into a shorter-appearing survey.

The pilot study sample included was predominently female and Caucasian, which is fairly representative of school counselors in the state of North Carolina. Use of random sampling procedures, however, should provide a better approximation of the ethnic and gender diversity of the target population. In addition, the participants in the pilot study were primarily employed in high schools in a specific geographic region of North Carolina. In order to reach school counselors serving a variety of school settings, a stratified random sampling procedure will be utilized, where one third of selected participants each will be drawn from elementary schools, middle schools, and high schools. Due to random sampling, it is anticipated that participants selected also will represent a wide number of school districts in the state of North Carolina.

Although tentative due to the small number of participants, pilot study results for the CIDQ showed promise of good internal consistency. A primary goal of the main study was further examination of the psychometric properties of the CIDQ with a much larger and more diverse sample. In addition, due to the small sample size, it was not feasible to perform some of the higher level statistical analyses required for hypothesis testing. Partial support was found, however, for the hypothesis regarding crisis frequency predicting higher levels of school counselor burnout.

In conclusion, this section included discussion of purposes and procedures of a pilot study to field test instrumentation and research design for the main study. Results of the pilot study indicated initial support for internal consistency reliability of the CIDQ and some tentative support for hypotheses. Modifications to make the instrumentation shorter and more user-friendly were incorporated and can be found in Appendix E.

Procedures

Prior to data collection, all proposed procedures, methodology, and instrumentation were approved by the Human Subjects Review Board at the University of North Carolina at Greensboro. Potential participants were invited to respond to the survey through a mailed packet containing a cover letter, assessment packet, and contact form. Specific details about the research study, including purposes, procedures, informed consent information for the study, and directions were contained in the cover letter. In order to balance the chance that the order of the instruments in the survey packet would impact the responses (e.g., participants might feel more or less burned out after examining their crisis intervention skills based on their responses), ordering of the BMS and CIDQ were random. In order to improve response rates, participants who chose to respond were included in a random drawing for a monetary incentive (Yu & Cooper, 1983).

Because sending multiple reminders may increase both generalizability of study results and participation (Linsky, 1975; Shannon & Bradshaw, 2002), two sets of reminder postcards were sent at 10 day intervals to non-respondents from the initial

mailing. Code numbers were used on all distributed packets in order to track non-respondents as accurately as possible.

Data Analysis

After completion of the data collection period, all results were entered into SPSS 14.0 for Windows (SPSS, Inc., 2005) for data analysis. Analyses and variables for hypotheses can be located in Table 7.

Table 7

Analyses and Variables for Main Study Hypotheses

Hypothesis	Variables	Analyses
Hypothesis 1	CIDQ Item 1	Descriptive Statistics
Hypothesis 2	CIDQ Item 2	Descriptive Statistics
Hypothesis 3	CIDQ Items 3 – 37	Descriptive Statistics
Hypothesis 4	CIDQ Items 3 – 37	Descriptive Statistics
Hypothesis 5	CIDQ Items 38 – 41	Descriptive Statistics
Hypothesis 6	CIDQ Items 42	Descriptive Statistics, Factor Analysis
Hypothesis 7	CIDQ Demographic Questionnaire	Multiple Analyses of Variance (MANOVA) Analysis of Variance (ANOVA)
Hypothesis 8	CIDQ Items 1 – 2 BMS	Multiple Regression Bivariate Correlations
Hypothesis 9	CIDQ Items 3 – 37 BMS	Multiple Regression

Descriptive statistics, examination of missing data, and reliability analyses were run for all variables. In addition, a factor analysis was run to explore the types of skills that professional school counselors value, multivariate analyses of variance (MANOVA) were run to determine any reported differences in variables by demographic factors, and

multiple regressions were run to determine whether crisis frequency and severity predicted burnout. Finally, a multiple linear regression was used to examine any evidence that crisis intervention training might moderate professional school counselor burnout. An alpha level of 0.05 was used for all statistical measures.

Limitations

There are several a priori limitations that should be noted. First, it was anticipated that a portion of potential participants would choose not to respond to the survey. Although measures were taken to maximize response rates and minimize non-response, it is possible that there are variables on which respondents and non-respondents differed. This may be especially pertinent because one of the variables examined in this study was burnout. Due to the nature of burnout (especially emotional exhaustion and depersonalization), those school counselors who were experiencing particularly high levels of burnout may have been less likely to respond than those school counselors who were experiencing less burnout. Further, those who experienced burnout at a clinical level may no longer have been employed within the school system, due to their decreased sense of efficacy and professional accomplishment. Therefore, the measure of burnout may not have reflected the entire range of the continuum that exists among school counselors. Additionally, the assessment of burnout was cross-sectional. Environmental factors, therefore, may have impacted participants, resulting in potential historical bias.

A second limitation of the study was the reliance on self-report. Although confidentiality was assured and precautions were taken to minimize self-report bias, participants may have responded in a socially desireable way. Alternatively, it is possible

that respondents who were experiencing high levels of burnout may have over-reported crisis levels in their school as a function of their burnout or have limited their contact with students as a result of their emotional exhaustion and depersonalization. In either case, there may be some subjectivity bias in the self-report data.

A third potential limitation is that participants were drawn from one state. Due to the limited number of training programs in the state, it is possible that variation in training experiences and programs might be limited. Another potential limitation specific to training experiences was that respondents who graduated more recently may have had an easier time completing the CIDQ accurately, whereas respondents who have had extensive school counseling experience may have had more difficulty remembering courses they took, the amount and type of informal educational experiences they have attended, and how helpful they perceived those experiences to be. Therefore, the training scales may reflect more of a perception of amount of training received and aggregate helpfulness of that training, as opposed to a precise measurement.

CHAPTER IV

RESULTS

In Chapter II, the level of individual crises in the schools, the crisis intervention training of school counselors, the crisis intervention skills and resources used by school counselors, and the level of burnout reported by school counselors were explored. In Chapter III, the methodology of this study was delineated. In this chapter, the results of the study are presented. First, the sample is described, and instrument descriptives and reliabilities are presented. Finally, results for study hypotheses are presented, and relevant post hoc analyses are presented and discussed.

Resulting Sample

Of the 825 individuals who were randomly selected for participation in this study, 146 responded to the questionnaire or contacted the researcher. Six packets were returned as nondeliverable by the Postal Service, two were returned by individuals stating the contact person was unavailable due to military service or retirement. Twelve were not admissible for data collection according to preset criteria. Specifically, seven did not agree to participate, two did not identify as school counselors, and three had not yet completed their master's degree. The final response rate for the study based on completed surveys is 16% (n = 132).

Table 8 contains a summary of participant demographics including gender, ethnicity, age, experience, degree status, level of students served, credentials, and prior teaching experience. As displayed in Table 8, 87.9% (n = 116) of participants were female. One hundred nine participants (82.6%) were White, 17 (12.9%) were Black, one (0.8%) was Latino/Latina, two (1.5%) were Native American, one (0.8%) was bi/multiracial, and one (0.8%) identified as "other." One participant declined to specify ethnicity. Participants ranged in age from 25 to 65 years of age (M = 43.56, SD = 10.79) with approximately half between the ages of 34 and 53. Three participants (2.3%) declined to report their age.

Study participants were elementary (n = 48; 36.4%), middle (n = 38; 28.8%), and high school (n = 29; 22.0%) counselors. In addition, 16 participants (12.1%) reported serving grades that crossed multiple levels (i.e. k-8, 6-12, k-12, etc.). For analysis purposes, these counselors have been pooled into a separate category, due to blending between two or more traditional levels of schools. One respondent (0.8%) declined to report grade level. Just over 90% (n = 118) had a master's degree, 8.4% (n = 11) had received an Ed.S. or post-master's certificate, and 1.5% (n = 2) had completed a doctorate. Participants reported between 0.5 and 31 years of professional counseling experience (M = 11.55, SD = 8.36), with between 0.25 and 31 years serving in their current positions (M = 6.74, SD = 6.06). A total of 13.0% (n = 17) reported less than three years of experience, 48.9% (n = 64) reported less than 10 years of experience, and 9.9% (n = 14) reported 24 or more years of experience. Participants held a variety of credentials including Licensed Professional Counselor (n = 22; 16.9%), National

Certified Counselor (*n* = 33; 25.0%), National Certified School Counselor (*n* = 23; 17.4%), and National Board Certified through the National Board for Professional Teaching Standards (*n* = 19; 14.4%). Eighty five participants (64.4%) reported having a North Carolina school counseling license. Regarding counselor preparation, 71 participants (53.8%) indicated that their masters program was CACREP accredited.

Table 8

Selected Demographics of School Counselors by Level

	Elementary		Middle		High		Blended		Total sample	
	n	%	*n*	%	*n*	%	*n*	%	*N*	%
GENDER										
Female	44	91.7	32	84.2	26	89.7	14	87.5	116	87.9
Male	4	8.3	6	15.8	3	10.3	2	12.5	15	12.1
Total	48	100	38	100	29	100	16	100	131	100
ETHNICITY										
Asian	0	0	0	0	0	0	0	0	0	0
Black	3	6.3	9	23.7	3	10.3	2	12.5	17	12.9
Latino/a	0	0	0	0	1	3.4	0	0	1	0.8
Native American	0	0	0	0	1	3.4	1	6.3	2	1.5
White	44	91.7	29	76.3	24	82.8	12	75.0	109	82.6
Biracial/multiracial	1	2.1	0	0	0	0	0	0	1	0.8
Other	0	0	0	0	0	0	1	6.3	1	0.8
Total	48	100	38	100	29	100	16	100	131	100
AGE										
29 years or less	5	10.6	5	13.2	4	14.3	2	12.5	16	12.4
30-39 years	19	40.4	9	23.7	7	25.0	3	18.8	38	29.5
40-49 years	10	21.3	6	15.8	3	10.7	8	50.0	27	20.9
50 years or more	13	27.7	18	47.4	14	50.0	3	18.8	48	37.2
Total	47	100	38	100	28	100	16	100	129	100
YEARS OF EXPERIENCE										
Less than 3 years	4	8.3	6	15.8	5	17.2	2	12.5	17	13.0
3-10 years	23	47.9	15	39.5	9	31.0	4	25.0	51	38.9
11-20 years	15	31.3	9	23.7	7	24.1	8	50.0	39	29.8
21 years or more	6	12.5	8	21.1	8	27.6	2	12.5	24	18.3
Total	48	100	38	100	29	100	16	100	131	100

DEGREE STATUS										
Masters	45	93.8	35	92.1	24	82.8	13	86.7	118	90.1
EdS or Certificate	3	6.3	3	7.9	3	10.3	2	13.3	11	8.4
Doctorate	0	0	0	0	2	6.9	0	0	2	1.5
Total	48	100	38	100	29	100	15	100	131	100
MASTERS PROGRAM CACREP-ACCREDITED										
Yes	30	62.5	15	39.5	15	53.6	11	68.8	71	53.8
No	6	12.5	5	13.2	7	25.0	2	12.5	20	15.5
Not sure	11	22.9	18	47.4	6	21.4	3	18.8	38	29.5
Total	47	100	38	100	28	100	16	100	129	100
TEACHING EXPERIENCE										
Yes	21	43.8	14	37.8	12	41.4	7	43.8	54	41.5
No	27	56.3	23	62.2	17	58.6	9	56.3	76	58.5
Total	48	100	38	100	29	100	16	100	130	100

Note. * indicates valid percent endorsing. Percentages may not add up to exactly 100 due to rounding.

Instrument Descriptives

Participants completed a demographic instrument, the Crisis Intervention Descriptive Questionnaire (CIDQ), and the Burnout Measure, Short Version (BMS). In this section, item and factor analyses for the CIDQ are provided before addressing the descriptive statistics and reliability information for the BMS and the CIDQ.

Crisis Intervention Descriptive Questionnaire

The Crisis Intervention Descriptive Questionnaire (CIDQ) contained a total of 12 items that comprised four sections. The first section, *Crisis Experiences*, contained four multi-part items detailing exposure to individual crises over an entire career, frequency of those crises over the previous 12 months, participants' perceptions of the importance and changeability of those crises, and perceived effectiveness with crisis issues. Exposure over an entire career was scored on a dichotomy—participants responded either "yes" or "no." For frequency of crises, participants were asked to note how many times they had encountered each specific crisis. Importance and changeability were rated on a 10-point

scale (i.e. 1 = not important or not changeable; 10 = extremely important or extremely changeable). Perceived effectiveness was rated on a four point scale ranging from "not effective" to "very effective."

The second section, *Crisis Training*, consisted of four multi-part items inquiring about history of taking semester-long crisis courses, content of crisis courses (if applicable), and crisis training experiences both during and after the master's degree program. Participants were asked to indicate which individual crisis topics were covered in any semester-long crisis intervention coursework by selecting "yes" or "no." Informal training experiences were measured by indicating what type of training was attended, the number of those training experiences attended, the most recent training experience, and the perceived helpfulness of that training experience, which was recorded on a four-point scale (1 = not helpful, 4 = very helpful).

The third section, *Resources*, consisted of one multi-part item and one open-ended response. The multi-part item asked for the perceived utility of 24 different crisis intervention resources, including physical resources (e.g., textbooks, websites, etc.), in-house personnel (e.g., school social worker, other school counselors on-site, etc.), and external personnel (e.g., community counselors, central office personnel, etc.). Participants responded to the perceived usefulness of these resources on a four-point scale (1 = not useful to 4 = very useful). The open-ended question inquired about resources that had been particularly helpful, and was not analyzed for this dissertation study.

The fourth section, *Skills*, consisted of one multi-part item and one open-ended item. The multi-part item assessed the perceived necessity of 64 skills generated through a review of the literature and consultation with experts in crisis intervention and school counseling as well as school counselor's perceived comfort levels with those 64 skills. Perceived necessity was rated on a four-point scale with 1 = not necessary, 2 = slightly necessary, 3 = necessary, and 4 = vital. Perceived comfort also was rated on a four-point scale, with 1 = not comfortable, 2 = slightly comfortable, 3 = comfortable, and 4 = very comfortable. The open-ended question inquired about reactions that participants might have had while responding to the skills section of the questionnaire. Responses to the open-ended question were not analyzed for this dissertation study.

Itemized responses for crisis exposure on the *Crisis Experiences* section of the CIDQ are displayed in Table 9. Descriptive responses of the crisis importance and crisis changeability responses on the *Crisis Experiences* section of the CIDQ are displayed in Table 10. These tables include percentage of participants responding to the item, frequencies (in percentage) of all responses, mean of responses, and standard deviation of responses.

Table 9

Descriptives of Ratings for Crisis Exposure Segment of CIDQ

Crisis Situation	*N*	Yes	No
Physical Abuse	131	100%	0%
Suicidal Ideation	132	97.0%	3.0%
Physical Aggression/Bullying	131	96.2%	3.8%
Relational Aggression/Bullying	131	96.2%	3.8%
Neglect	132	96.2%	3.8%
Severe Mental Health Issues	130	93.8%	6.2%
Self-Injurious Behavior	132	89.4%	10.6%
Sexual Abuse	129	89.1%	10.9%
Other School Violence	125	85.6%	14.4%
Suicidal Intent	129	75.2%	24.8%
Suicidal Behavior	130	69.2%	30.8%
Gang Violence	117	33.3%	66.7%

To account for missing data, valid percentages are reported.

Table 10

Descriptive Statistics of Crisis Importance and Changeability Segment of CIDQ

	Importance					Changeability				
Crisis Situation	*N*	*M*	*SD*	*Min.*	*Max.*	*N*	*M*	*SD*	*Min.*	*Max.*
Suicidal Behavior	130	9.55	1.52	1	10	124	8.47	1.86	1	10
Suicidal Intent	130	9.45	1.65	0	10	124	8.51	1.98	0	10
Sexual Abuse	126	9.43	1.75	0	10	123	6.82	2.47	0	10
Physical Abuse	129	9.36	1.51	1	10	125	6.96	2.12	1	10
Suicidal Ideation	129	9.20	1.69	1	10	125	8.63	1.76	1	10
Neglect	129	9.16	1.62	1	10	125	6.72	2.22	1	10
Gang Violence	119	9.03	1.81	0	10	112	5.71	2.65	0	10
Severe Mental Health Issues	129	8.89	1.85	0	10	122	5.89	2.43	0	10
Self-Injurious Behavior	129	8.83	1.72	0	10	125	7.35	2.05	0	10
Physical Aggression/Bullying	130	8.50	1.69	1	10	124	7.20	2.00	1	10
Other School Violence	127	8.43	1.93	1	10	119	6.97	2.23	1	10
Relational Aggression/Bullying	130	8.35	1.70	1	10	124	7.01	2.16	1	10

An initial principal components factor analysis of the 128 skills necessity and skills comfort items returned a 9 factor solution accounting for 54.9% of the variance in the model. Due to the desired two scale solution, a two-factor principal components factor analysis was run with varimax rotation. The resulting factor structure accounted for 33.0% of the variance, and factors were clearly delineated into a skills necessity factor and a skills comfort factor, as 62 of the 64 skills necessity items loaded onto the first factor and 63 of the 64 skills comfort items loaded onto the second factor. The two skills necessity items that loaded on the second factor had low loading scores, as did the single skills comfort item that loaded on the first factor. Although these two factors only supplied 33.0% of the variance, this factor analysis provides initial support to the inclusion of two different scales: a skills necessity scale and a skills comfort scale. A total of four necessity skills items were discarded, due to crossloading or factoral complexity. A total of five comfort skills items were discarded due to crossloading or factoral complexity. Table 11 contains eigenvalues for this solution. The rotated component matrix is reproduced in Appendix G.

Table 11

Eigenvalues for Factor Analysis of Crisis Skills Items

Factor	# Items	Initial Eigenvalues			Rotation Sums of Squared Loadings		
		Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %
Necessity	60	32.18	25.14	25.14	21.70	16.95	16.95
Comfort	59	10.06	7.86	33.00	20.54	16.15	33.00

Although further exploratory factor analysis was planned in order to ascertain evidence of further factor structure in the skills necessity scale and the skills comfort scale, due to the limited sample size, it was determined that factor analysis of the remaining 119 items would not be statistically sound.

Descriptive statistics for the revised CIDQ skills necessity and skills comfort scales were then calculated. Descriptive statistics for all CIDQ scales, including the revised crisis skills necessity and crisis skills comfort scales are displayed in Table 12. Pearson Product-Moment correlations and alphas for CIDQ Scales were calculated and results are displayed in Table 13.

Table 12

Descriptive Statistics for CIDQ Scales

Scale	*N*	*M*	*SD*	Minimum	Maximum	Scale Min	Scale Max
Crisis Exposure	132	10.05	1.88	4	12	0	12
Crisis Frequency	97	50.03	41.67	1	228	0	N/A
Crisis Training	77	8.05	3.52	0	14	0	14
Crisis Resources	41	66.24	11.77	39	85	24	96
Original Crisis Skills Necessity	97	218.10	22.22	166	256	64	256
Original Crisis Skills Comfort	97	199.21	25.85	147	256	64	256
Revised Crisis Skills Necessity	104	205.08	21.30	153	240	60	240
Revised Crisis Skills Comfort	101	182.32	24.05	133	236	59	236

Table 13

Pearson Product-Moment Correlations and Alphas for CIDQ Scales

	Exposure	Frequency	Training	Resources	Revised Skills Necessity	Revised Skills Comfort
Exposure	**.73**					
Frequency	.29**	**.79**				
Training	.22	.16	**.82**			
Resources	-.29	-.02	.24	**.89**		
Revised Skills Necessity	.02	.16	.08	.41*	**.96**	
Revised Skills Comfort	.18	.19	.38**	.31	.52**	**.96**

Note.. The lower triangle contains Pearson Product Moment correlations; the diagonal contains Cronbach's alpha coefficients for the subscale. * $p < .05$ (2-tailed) ** $p < .01$ (2-tailed)

Descriptive statistics (e.g., means, standard deviations, ranges of scores) and internal consistency reliabilities were computed for the skills, skills necessity, skills comfort, crisis exposure, and crisis frequency scales. This information is presented in Table 14 along with possible minimum and maximum scores for each instrument and scale. Internal consistency reliabilities were acceptable for all sections of the CIDQ (0.73-0.95), but were lower for the crisis exposure and crisis frequency scales (0.73 and 0.79, respectively). The current evidence of the internal consistency reliability for the BMS was consistent with the reliability reported in the literature (α= 0.89). The obtained ranged of scores was somewhat constricted on the skills necessity section, with a range of 87 (out of a possible 180). The mean scores for the revised skills necessity and skills comfort subscales were negatively skewed (M = 205.08 and M = 182.32 respectively).

Table 14

Cronbach's Alpha and Descriptive Statistics for CIDQ and BMS

Scale	Subscale	Items	*α*	*M*	*SD*	Obs Min	Obs Max	Scale Min	Scale Max
CIDQ	Crisis Exposure	12	.73	10.05	1.88	4	12	0	12
CIDQ	Crisis Frequency	12	.79	50.03	41.67	1	228	0	N/A
CIDQ	Crisis Importance	12	.95	109.24	14.94	12	120	12	120
CIDQ	Crisis Changeability	12	.91	86.85	18.77	16	120	12	120
CIDQ	Crisis Training	14	.82	8.05	3.52	0	14	0	14
CIDQ	Crisis Resources	24	.89	66.24	11.77	39	85	24	96
CIDQ	Skills Necessity	60	.96	205.08	21.30	153	240	60	240
CIDQ	Skills Comfort	59	.96	182.32	24.05	133	236	59	236
BMS		10	.89	26.5	9.35	12	53	10	70

Burnout Measure: Short Version

As discussed in chapter three, the Burnout Measure: Short Version (BMS) used in this study contained a total of 10 items. Items were marked on a seven-point scale ranging from 1 to 7 with higher rankings indicating higher levels of burnout symptomology. Internal consistency reliability was acceptable ($\alpha = 0.89$) and consistent with the reliabilities reported with other samples in the literature. Table 15 contains the mean scores, standard deviations, observed minimum, and observed maximum ratings for the BMS.

Table 15

Descriptive Statistics for BMS Items and BMS Total

Item	*N*	*M*	*SD*	Min	Max
Tired	132	4.44	1.23	2	7
Disappointed with people	132	3.80	1.05	1	6
Difficulties sleeping	132	2.87	1.56	1	7
"I've had it"	132	2.45	1.45	1	6
Helpless	132	2.30	1.41	1	6
Depressed	132	2.29	1.23	1	6
Hopeless	132	2.28	1.26	1	6
Physically weak/Sickly	132	2.26	1.35	1	7
Trapped	132	2.10	1.43	1	7
Worthless/Like a failure	132	1.71	1.12	1	6
BMS Total	131	26.47	9.35	12	53

Note. Items are scored on a 7-point scale ranging from 1 (never) to 7 (always).

Results of Research Hypotheses

Hypothesis 1

Hypothesis 1 stated that professional school counselors would encounter a variety of individual crises, including suicidal ideation, suicidal behavior, self-injurious behavior, violence, physical abuse, sexual abuse, and, severe mental health issues. Participants indicated that they did, indeed, experience a number of individual crises over their career. Of the respondents, all reported at least some exposure to crisis situations. Of those crisis situations reported, all had been exposed to child physical abuse (n = 131, 100%), and most had worked with suicidal ideation (n =128, 97%), physical bullying (n = 126, 96.2%), relational bullying (n = 126, 96.2%), and child neglect (n = 127, 96.2%). Fewer counselors reported exposure to suicidal behavior (n = 90, 69.2%) and gang violence (n

= 39, 33.3%). Multiple participants (*n* = 29, 22.0%) reported exposure to all twelve individual crisis situations identified, and over half (*n* = 70, 53.1%) reported exposure to at least 11 of the 12. See Table 16 for a complete listing of exposure to individual crisis situation, both by school level (i.e., elementary, middle, high, and blended) and overall. Hypothesis 1 was supported.

Table 16

Frequency (in Percentages) of Exposure to Individual Crises by School Level

Individual Crisis	Elementary		Middle		High		Blended		Total	
	n	%	*n*	%	*n*	%	*n*	%	*N*	%
Physical Abuse	48	100	38	100	28	100	16	100	131	100
Suicidal Ideation	46	95.8	38	100	29	100	14	87.5	128	97.0
Physical Aggression/Bullying	45	93.8	38	100	27	96.4	15	93.8	126	96.2
Relational Aggression/Bullying	47	97.9	36	94.7	28	96.6	14	93.3	126	96.2
Neglect	48	100	37	97.4	26	89.7	15	93.8	127	96.2
Severe Mental Health	45	93.8	37	100	24	85.7	15	93.8	122	93.8
Self-Injurious Behavior	39	81.3	37	97.4	28	96.6	13	81.3	118	89.4
Sexual Abuse	43	91.5	31	83.8	25	89.3	15	93.8	115	89.1
Other School Violence	37	80.4	33	91.7	26	92.9	10	71.4	107	85.6
Suicidal Intent	33	68.8	29	78.4	23	82.1	11	73.3	97	75.2
Suicidal Behavior	27	57.4	32	84.2	23	82.1	7	43.8	90	69.2
Gang Violence	6	14.3	16	45.7	13	52.0	4	28.6	39	33.3

To account for missing data, valid percentages are reported.

Hypothesis 2

Hypothesis 2 stated that some individual crises, such as suicidal ideation and child physical abuse would occur most frequently, with child sexual abuse, suicidal behavior, and suicidal intent occurring less frequently. Reported frequencies of crises varied considerably. Relational bullying within the past year was the most frequently reported

crisis (*M* = 11.97, *SD* = 14.84), followed by physical bullying (*M* = 10.40, *SD* = 15.78) and neglect (*M* = 4.88, *SD* = 5.90). Gang violence (*M* = 0.57, *SD* = 1.38), suicidal behavior (*M* = 1.34, *SD* = 1.95), suicidal intent (*M* = 1.39, *SD* = 2.33), and sexual abuse (*M* = 1.39, *SD* = 2.47) were the least frequently reported crises. It should be noted that, with the exception of gang violence, all means indicated an average of at least one incident per year. Descriptive statistics (mean, standard deviation, observed minimum, and observed maximum) of overall reported crisis frequency is provided in Table 17.

Table 17

Descriptive Statistics of Crisis Frequency Segment of CIDQ

Crisis Situation	*N*	*M*	*SD*	Minimum	Maximum
Relational Aggression/Bullying	121	11.97	14.84	0	75
Physical Aggression/Bullying	123	10.40	15.78	0	100
Neglect	129	4.88	5.90	0	30
Other School Violence	116	4.77	8.69	0	50
Severe Mental Health Issues	123	4.51	6.46	0	50
Suicidal Ideation	127	3.51	4.34	0	24
Physical Abuse	123	3.39	3.80	0	25
Self-Injurious Behavior	120	3.14	4.72	0	36
Suicidal Intent	114	1.39	2.33	0	12
Sexual Abuse	120	1.39	2.47	0	18
Suicidal Behavior	117	1.34	1.95	0	10
Gang Violence	110	0.57	1.38	0	8

This hypothesis was further addressed using a univariate analysis of variance (ANOVA) and post hoc Bonferroni t-tests to control for error rate given the number of analyses performed. In this case, the frequencies of each individual crisis (e.g., suicidal behavior, suicidal intent, suicidal ideation, self-injurious behavior, etc.) were the

dependent variables and the participant's employment at elementary school, middle/junior high school, high school, or blended (i.e. k-8, 6-12, pre-k-12, etc.) settings was the independent variable. Results for the ANOVA are presented in Table 18, and effect size is reported. In order to control for Type I error, the alpha level was adjusted to accommodate multiple ANOVA analyses. The adjustment was obtained by dividing the desired significance level ($\alpha = .05$) by the total number of ANOVAs run (12) for a resulting significance level of $\alpha = .004$. Significant differences were found by grade level for suicidal behavior, suicidal ideation, suicidal intent, self-injurious behavior, relational aggression/bullying, gang violence, and neglect.

Table 18

ANOVA of CIDQ Crisis Frequency by School Level

	Df	*F*	η^2
Self-Injurious Behavior	121	8.609*	.180
Suicidal Behavior	118	6.325*	.142
Gang Violence	110	5.980*	.144
Neglect	127	4.772*	.104
Suicidal Ideation	126	4.099	.091
Suicidal Intent	113	2.885	.073
Physical Abuse	123	2.635	.062
Relational Aggression/Bullying	121	2.304	.055
Other School Violence	117	2.037	.051
Physical Aggression/Bullying	122	1.432	.035
Sexual Abuse	120	1.135	.028
Severe Mental Health Issues	124	.394	.001

* $p < .004$

Post-hoc Bonferroni t-tests allowed for pinpointing between-group differences without artificially inflating the error rate. Results of this procedure indicated that elementary school counselors reported fewer incidents of suicidal behavior ($M = 0.52$,

SD = 1.15) than either middle school or high school counselors (*M* = 2.00, SD = 2.21 and *M* = 2.08, SD = 2.36, respectively) and fewer incidents of suicidal ideation (*M* = 2.15, SD = 2.07) than middle school counselors (*M* = 4.78, SD = 5.62). Frequency rates of self-injurious behavior were significantly lower for elementary school counselors (*M* = 1.02, SD = 1.19) than both middle school counselors (*M* = 4.60, SD = 4.63) and high school counselors (*M* = 5.80, *SD* = 7.43). High school counselors reported a significantly higher level of gang violence (*M* = 1.33, SD = 2.26) than elementary school counselors reported (*M* = 0.05, SD = 0.22). Neglect was reported by elementary school counselors at a significantly higher rate (*M* = 6.94, SD = 7.35) than was reported by either middle school counselors (*M* = 3.35, SD = 4.96) or high school counselors (*M* = 2.64, SD = 3.32).

School counselors reported different frequencies of types of crises, with bullying being reported most often and gang violence being reported least often, and multiple incidents of different crises being reported during a one year period. Hypothesis 2 was supported.

Hypothesis 3

Hypothesis three stated that professional school counselors would report a variety of crisis intervention training, training experiences, including graduate level courses, coursework integrated into other courses, workshops, and in-service training experiences, but that some counselors would report having no crisis intervention training. Preparation regarding crisis intervention training varied with slightly less than one-third of the participants (31.3%) reporting having taken an academic, semester-long crisis course. Of

those who reported taking a crisis course, 12 (9.4%) reported it was required for their master's program. Eighty three participants (64.8%) reported that there was no crisis course available to them either during or after their master's program.

Participants also were asked to indicate participation in a variety of training experiences about the following crisis topic areas: suicidality, self-injurious behavior, bullying, gang and other school violence, child abuse and neglect, severe mental health issues, and critical incident stress debriefing (CISD). Of the 92 participants who filled the master's training section of the CIDQ out in its entirety, twenty participants (21.7%) reported having no training in any of the crisis topics during their master's programs. Only twenty participants (27.1%) reported having some level of training in at least six of the seven topic areas during their master's program. For the frequencies of participants reporting training in each of the seven areas, please refer to Table 19.

Of the 97 participants who completely responded to the post-master's section of the CIDQ, a majority of participants (n = 91, 93.8%) reported having at least some exposure to training around crisis topics post-master's degree completion, and just under half (n = 43, 44.3%) reported having some degree of training in at least six of the seven topic areas.

Overall, participants reported participating in a variety of training experiences, yet there were still multiple counselors who reported not having any exposure to crisis coursework or crisis topics. Therefore, Hypothesis 3 was supported.

Table 19

Frequency (in Percentages) of Crisis Training by Topic

Individual Crisis	Master's Training		Post-Master's Training	
	N	%	*N*	%
Suicide, Suicidal Behavior, and Suicidal Ideation	81	71.7	101	88.6
Severe Mental Health Issues	77	70.0	68	61.8
Child Abuse and/or Neglect	77	69.4	94	84.7
Self-Injurious Behavior	50	45.5	68	61.8
Physical and/or Relational Bullying	47	46.5	93	83.8
Gang Violence or School Violence	32	30.8	87	79.8
Critical Incident Stress Debriefing	31	29.5	67	59.8

Hypothesis 4

Hypothesis 4 stated that school counselors will, on average, perceive that crisis intervention training is helpful in addressing individual crises. Participants reported that training on topics of suicidality ($M = 3.27$, $SD = 0.67$) and critical incident stress debriefing (CISD; $M = 3.23$, $SD = 0.70$) training experiences were the most helpful. Participants rated the helpfulness of their training experiences on a four-point scale, with 1 = not helpful and 4 = very helpful. On this scale, participants' mean ratings of all training experiences were at minimum in the "helpful" range. Hypothesis 4 was supported. Itemized descriptive scores of helpfulness by topicare provided in Table 20. Because each training experience listed was included in this analysis, the n-sizes listed in Table 20 may be higher than the total sample size.

Table 20

Descriptive Statistics of Crisis Training Helpfulness by Topic

Crisis Situation	*N*	*M*	*SD*	Minimum	Maximum
Suicide, Suicidal Ideation, and Suicidal Behavior	210	3.27	0.67	1	4
Critical Incident Stress Debriefing	103	3.23	0.70	2	4
Child Abuse and/or Neglect	189	3.19	0.69	1	4
Severe Mental Health Issues	154	3.19	0.72	2	4
Gang Violence and School Violence	137	3.10	0.76	1	4
Physical and/or Relational Bullying	164	3.05	0.72	1	4
Self-Injurious Behavior	126	3.04	0.82	1	4

Hypothesis 5

Research question 5 focused primarily on the perceived usefulness of the crisis resources used by school counselors. Due to its exploratory nature, there was no hypothesis regarding the overall usefulness of crisis resources. Overall, participants reported that on-site school counselors were the most useful resources when they were available (M = 3.42, SD = 0.81), followed by crisis intervention manuals (M = 3.29, SD = 0.77), school counselors at other schools (M = 3.15, SD = 0.79) district crisis plans (M = 3.13, SD = 0.92), school social workers (M = 3.11, SD = 0.98), and school resource officers (M = 3.02, SD = 0.93), while textbooks (M = 2.18, SD = 0.83) the magistrate (M = 1.90, SD = 0.91), and lawyers/attorneys (M = 1.86, SD = 0.95) were the least useful. It should be noted that some resources had fewer responses than others, due to lack of access (e.g., being the only school counselor on-site). In addition to those resources that were listed on the questionnaire, several responses also were written in by participants, including DSS/CPS (n = 4, M = 2.25, SD = 0.50), local psychiatric hospitals (n = 2, M =

3.00, *SD = 0.00*), specific programs targetting adolescents (e.g., Wake Teen, Communities in Schools; *n* = 2, *M* = 3.50, *SD* = 0.71), group homes (*n* = 1, *M* = 1.00), parents of students (*n* = 1, *M* = 2.00), students' peers (*n* = 1, *M* = 2.00), court counselors and probation officers (*n* = 1, *M* = 3.00), and pastors (*n* = 1, *M* = 4.00). For a complete list of perceived usefulness of resources, please refer to Table 21.

Table 21

Perceived Usefulness of Resources

		Perceived Helpfulness			
Resource	*N*	Minimum	Maximum	*M*	*SD*
Other On-Site School Counselors	89	1	4	3.42	0.81
Crisis Intervention Manuals	129	1	4	3.29	0.77
School Counselors at Other Schools	128	1	4	3.15	0.79
District Crisis Plan	129	1	4	3.13	0.92
School Social Worker	116	1	4	3.11	0.98
School Resource Officer	103	1	4	3.02	0.93
Administrators	128	1	4	2.91	0.90
School Nurse	122	1	4	2.91	0.91
Websites	125	1	4	2.85	0.85
Director of Student Services	115	1	4	2.83	1.04
School Psychologist	113	1	4	2.73	1.13
Community Counselors	115	1	4	2.67	1.03
Exceptional Children Teacher	127	1	4	2.62	0.92
Law Enforcement	111	1	4	2.55	0.88
Journal Articles	123	1	4	2.47	0.79
Psychologists	110	1	4	2.42	0.96
Teacher	129	1	4	2.35	0.85
Central Office Personnel	127	1	4	2.32	1.00
Psychiatrists	103	1	4	2.32	0.93

School Counselor Educators	95	1	4	2.28	1.07
Hotline/Crisis Phone Specialists	99	1	4	2.20	0.94
Textbooks	114	1	4	2.18	0.83
Magistrate	82	1	4	1.90	0.91
Lawyer/Attorney	88	1	4	1.86	0.95

Hypothesis 5b stated that school counselors would utilize a variety of resources, but would find *on-site personnel* (e.g. other school counselors, administrators) most helpful, as opposed to *physical* and *external personnel* resources. Mean total *physical resource*, *on-site personnel*, and *external personnel* scores were calculated in order to determine whether particular sets of resources might be more or less useful than others, and these descriptive statistics are provided in Table 22. Independent samples t-tests were calculated to determine any significant mean differences between the three mean scores. *External personnel* were significantly less useful at the $p > 0.001$ level than either *physical resources* ($t = -4.88$) or *on-site personnel* resources ($t = -5.97$), but that there was no significant difference between the mean usefulness scores of *physical resources* and *on-site personnel* ($t = 1.15$, $p = 0.25$). Thus, hypothesis 5b was partially supported.

Table 22

Descriptive Statistics of Resources by Type

Type of Resource	*N*	Minimum	Maximum	*M*	*SD*
On-Site Personnel	68	1.38	4.00	2.89	0.63
Physical Resources	108	1.20	4.00	2.80	0.55
External Personnel	61	1.09	3.64	2.40	0.63

Hypothesis 6

Hypothesis 6 stated that school counselors would identify assessment, ethical decision-making, and direct intervention skills as most important. As stated earlier, an exploratory factor analysis was run to explore the validity of having both a skills necessity and a skills comfort scale. Due to a limited sample size, however, it was not possible to explore further factor structure to determine whether there were skills subsets that were perceived as more or less necessary or comfortable by participating school counselors. Therefore, the skills were examined on an individual level, as opposed to in factor clusters.

Participants rated "assess potential danger to self and others" as having the highest level of necessity (M = 3.87, SD = 0.81), followed by "provide support to the student" (M = 3.80, SD = 0.42), and "identify students exhibiting indicators of suicidal ideation and suicidal intent" (M = 3.80, SD = 0.40). "Provide comprehensive case presentation for peers/administrators" (M = 2.60, SD = 0.85) was perceived as the least necessary, followed by "provide psychoeducation about the crisis" (M = 2.75, SD = 0.84) and "work independently, using technology to communicate and facilitate interaction" (M = 2.84, SD = 0.92). For an itemized list of descriptives of the revised skills necessity items please refer to Appendix H.

For the comfort ratings, participants rated "consult with school counseling peers in managing crisis situation" as being the most comfortable (M = 3.65, SD = 0.55), followed by "quickly establish rapport with a student" (M = 3.63, SD = 0.54), and "make DSS/CPS reports" (M = 3.52, SD = 0.75). "Provide psychoeducation about the crisis" (M

= 2.36, *SD* = 0.87) was rated the least comfortable skill, followed by "provide Critical Incident Stress Debriefing" (*M* = 2.47, *SD* = 0.91) and "identify students exhibiting indicators of sexual abuse" (*M* = 2.47, *SD* = 0.91). An itemized list of descriptives of the revised skills comfort items is provided in Appendix H.

Hypothesis 7

Hypothesis 7 stated that there would be no difference in participant preparation, usefulness of resources, skills necessity, skills comfort, or burnout related to individual or school demographics and characteristics. Dependent variables for these analyses included participant ratings of usefulness of resources, skills necessity, skills comfort, and burnout, in addition to participant reports of master's level and post-master's level training. Independent variables reflecting individual characteristics included years of counseling experience (grouped into quartiles), age (grouped into quartiles), and presence or absence of teaching experience. Independent variables reflecting school demographics and characteristics included level of school (i.e., elementary, middle, high, and blended), socioeconomic composition (as defined by percentage of students population receiving free or reduced lunches grouped into quartiles), minority composition (as defined by percentage of students of color grouped into quartiles) and presence or absence of other school counselors on-site. In order to test this hypothesis, a multivariate analysis of variance (MANOVA) was run to determine any main effects that these school and individual characteristics might have on the dependent variables of school counselor training, usefulness of resources, skills necessity, skills comfort. Wilks' Lambda was used for all MANOVA calculations. In addition, a univariate analysis of variance

(ANOVA) was run to determine any mean differences these independent variables had on the dependent variable of burnout.

Results of a MANOVA examining mean differences of training experiences (i.e., total master's level crisis training experiences and total post-master's crisis training experiences), based on individual characteristics (i.e. age, years of counseling experience, and teaching background) revealed a main effect of years of counseling experience on post-master's training ($F = 2.214$, $p < 0.05$), but subsequent post-hoc analyses were nonsignificant.

Results of a MANOVA examining mean differences of training experiences (i.e., total master's level crisis training experiences and total post-master's crisis training experiences) based on school demographics and characteristics (i.e., total school enrollment grouped by quartile, school level, school socioeconomic composition, school minority composition, and presence or absence of other school counselors on-site) revealed a main effect of school enrollment on post-master's crisis training experiences ($F = 3.14$, $p < 0.05$). Post-hoc analyses, however, were nonsignificant. In addition, a main effect of presence of other school counselors on-site on training experience was revealed ($F = 4.05$, $p < 0.05$). Post-hoc analyses revealed that participants who were the sole school counselors at their sites reported fewer post-master's crisis training experiences.

Results of a MANOVA examining mean differences between reported helpfulness of physical, on-site personnel, and external personnel resources based on individual characteristics (i.e. age grouped by quartile, years of counseling experience grouped by quartile, and teaching background) revealed a main effect of age on perceived

helpfulness of physical resources ($F = 3.61$, $p < 0.05$). Post-hoc analyses revealed that the fourth quartile (the oldest 25%) of participants perceived that physical resources (i.e., textbooks, journal articles, web sites, etc.) were less helpful than those in the 2nd quartile perceived them to be. Results of a MANOVA examining mean differences between reported helpfulness of physical, on-site personnel, and external personnel resources based on school demographics and characteristics (i.e., school level, school socioeconomic composition, school minority composition, and presence or absence of other school counselors on-site) revealed no significant main effects.

Results of a MANOVA examining mean differences between reported skills comfort and skills necessity scores based on individual characteristics (i.e. age grouped by quartile, years of counseling experience grouped by quartile, and teaching background) revealed no significant main effects. A MANOVA examining mean differences between reported skills comfort and skills necessity scores based on school demographics and characteristics (i.e., enrollment grouped by quartile, school level, school socioeconomic composition grouped by quartile, school minority composition grouped by quartile, and presence or absence of other school counselors on-site) revealed a significant main effect of presence or absence of another on-site school counselors on comfort level with crisis skills ($F = 15.77$, $p < 0.001$). Those participants who reported being the sole school counselor on site reported significantly less comfort with crisis intervention skills than participants who were not the only school counselor on-site. Although there were three significant main effects, overall, level of crisis training, perceived helpfulness of resources, and perceived skills necessity and skills comfort seem

to be primarily independent of the demographics and characteristics of the individual responding and the type of school. The within-groups MANOVA results for the previous results can be found in Table 23.

Results of an ANOVA with total burnout score as a dependent variable and individual characteristics (i.e. age, years of counseling experience, and teaching background) as independent variables revealed no significant main effects. Further, results of an ANOVA with total burnout score as a dependent variable and school demographics and characteristics (i.e., enrollment grouped by quartile, school level, school socioeconomic composition grouped by quartile, school minority composition grouped by quartile, and presence or absence of other school counselors on-site) as independent variables also revealed no significant main effects. Hypothesis 7 was partially supported.

Table 23

MANOVA Within-Group Results: Individual and School Characteristics by Training, Usefulness of Resources, and Skills

	Within Group					
	School Counselor Training (master's v. post-master's)			Usefulness of Resources		
	df	F	η²	df	F	η²
Individual Characteristics						
Years of Counseling Experience	6	2.214	.084	9	1.316	.100
Age	6	2.086	.081	9	1.671	.127
Teaching Experience	2	.821	.022	3	1.052	.079
School Characteristics						
School Level	6	.452	.018	9	1.117	.086
Socioeconomic Composition	6	.516	.027	9	.693	.068
Minority Composition	6	1.542	.065	9	.898	.071
Presence of Another On-site SC	2	4.054*	.100	3	.258	.020

	Skills (necessity v. comfort)		
	df	F	η²
Individual Characteristics			
Years of Counseling Experience	6	1.722	.053
Age	6	.711	.023
Teaching Experience	2	1.811	.037
School Characteristics			
School Level	6	1.461	.045
Socioeconomic Composition	6	1.163	.047
Minority Composition	6	.851	.028
Presence of Another On-site SC	2	8.059**	.159

* $p < .05$; ** $p < .001$

Hypothesis 8

Hypotheses 8a and 8b focused primarily on the relationship between individual crises and burnout. Hypothesis 8a stated that higher exposure and frequency of crisis would correspond with higher levels of burnout. First, a multiple regression was run with exposure to crisis and total frequency of crisis as independent variables and total burnout score as a dependent variable in order to determine if there was a predictive relationship between total reported crisis frequency, total crisis exposure, and reported school counselor burnout score. The resulting model was nonsignificant ($R^2 = 0.008$, $F = 0.40$, $p = 0.67$). Coefficients for this analysis are provided in Table 24. In addition, there was no significant relationship between either total crisis frequency or total crisis exposure and reported level of burnout. Hypothesis 8a was not supported.

Table 24

Linear Regression of Crisis Exposure and Total Crisis Frequency on Burnout Scores

Model		Unstandardized Coefficients		Standardized Coefficients	t	*P*
		B	Std. Error	Beta		
1	(Constant)	24.180	5.001		4.835	.000
	Total Exposure	.148	.510	.031	.289	.773
	Total Frequency	.017	.023	.078	.722	.472

Dependent Variable: Burnout Score

Hypothesis 8b stated that some crises would be related to higher levels of burnout than others. A stepwise regression was run with the twelve individual crisis frequency

scores serving as independent variables and burnout level as a dependent variable in order to determine whether any of them significantly predicted burnout level. Of the twelve, only frequency of physical abuse significantly predicted total burnout score (F = 2.55, $p < 0.05$), accounting for 6.5% of the variance in total burnout. Coefficients from variables included in this regression are provided in Table 25 and coefficients from variables excluded are provided in Table 26.

Table 25

Included Variables from Stepwise Regression of Crisis Frequency on Burnout Scores

Model		Unstandardized Coefficients		Standardized Coefficients	t	*p*
		B	Std. Error	Beta		
1	(Constant)	24.341	1.225		19.863	.000
	Physical Abuse Freq.	.656	.257	.254	2.548	.012

Dependent Variable: Total Burnout Score

Table 26

Excluded Variables from Stepwise Regression of Crisis Frequency on Burnout Scores

Model	Frequency of	Beta In	t	*p*
1	School Violence	.144(a)	1.448	.151
	Gang Violence	.056(a)	.560	.577
	Neglect	.073(a)	.486	.628
	Sexual Abuse	.032(a)	.270	.788
	Suicidal Behavior	.008(a)	.079	.937
	Severe Mental Health Issues	-.024(a)	-.233	.817
	Suicidal Ideation	-.041(a)	-.404	.687
	Relational Bullying	-.047(a)	-.436	.664
	Suicidal Intent	-.049(a)	-.468	.641
	Physical Bullying	-.140(a)	-1.319	.190
	Self-Injurious Behavior	-.145(a)	-1.454	.149

a Predictors: (Constant), physical abuse frequency b Dependent Variable: Total Burnout Score

Hypothesis 9

Hypothesis 9 stated that self perceived training would serve as a protective factor against burnout, and that increased levels of training would reduce levels of burnout due to crisis frequency and exposure. Although the original plan was to test a moderating model, this was not practical because neither crisis frequency nor crisis exposure were significant predictors of burnout. Thus, bivariate correlations and multiple linear regression analyses were run to determine if there was a predictive relationship between level of training during the master's program, level of training after completion of the master's program, total level of training, presence of semester-long crisis coursework, and burnout level. To initially explore the relationship between burnout levels and training, bivariate correlations were run to examine any significant negative relationships between types of crisis training and burnout levels. Both total training experiences and master's level training experiences were significant at the $p < 0.05$ level. Pearson Correlations of training variables, crisis coursework, and burnout levels are provided in Table 27.

Table 27

Pearson Correlations between Training Variables and Burnout Levels

	Total Training	Master's Level Training	Post-Master's Training	Burnout
Total Training				
Master's Level Training	.85**			
Post-Master's Training	.76**	.30**		
Burnout	-.31*	-.31*	-.24	
Crisis Coursework	.09	.16	-.00	.12

** Correlation is significant at the 0.01 level (1-tailed).
* Correlation is significant at the 0.05 level (1-tailed).

Then, a stepwise regression analyses was run to determine whether there was a significant predictive relationship, using master's level crisis training and post-master's crisis training as independent variables and burnout level as a dependent variable. Master's level crisis training accounted for 9.7% of the variance in burnout level (F = 4.31, $p < 0.05$). Post-Master's training did not add significantly to the prediction equation. Results from this regression are provided in Tables 28 and 29.

Table 28

Included Variables from Regression of Master's Training and Post-Master's Training on Burnout Levels

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	1.701	.132		12.867	.000
	Master's Level Training	-.065	.031	-.312	-2.077	.044

a Dependent Variable: Burnout Levels

Table 29

Excluded Variables from Regression of Master's Training and Post-Master's Training on Burnout Levels

Model		Beta In	T	*P*
1	pmtrain	-.157(a)	-.996	.325

a Predictors in the Model: (Constant), Master's Level Training
b Dependent Variable: Burnout Levels

Finally, in order to determine the relationship that individual training topics might have on levels of burnout, Pearson Correlations were run on training scores by topic and by level. The only significant relationships between burnout level and topic-specific training was with total CISD training ($r = -0.34$, $p < 0.05$) and master's level self-injurious behavior training ($r = -0.34$, $p < 0.05$). These two topic-specific crisis training experiences and total master's training experiences were then regressed onto burnout levels using a stepwise regression. The resulting model had only one variable entered, total CISD training that explained 14.8% of the variance in burnout level ($F = -2.46$, $p < 0.05$). Therefore, it appears that some types of training may relate to lower burnout scores, albeit modestly so. Hypothesis 9 was partially supported.

Summary

In this chapter, results of a study regarding the level of individual crises in the schools, the crisis intervention training of school counselors, the crisis intervention skills and resources tapped by school counselors, and the level of burnout reported by school counselors were reported. Participant demographics were discussed, factor analytic

procedures and resulting scales for the CIDQ skills necessity, skills comfort, and resources were provided, and instrument descriptives were detailed. Results of descriptive statistics, univariate analyses of variance (ANOVA), t-tests, bivariate correlations, multiple regression analyses, and multivariate analyses of variance (MANOVA) were reported. Hypotheses 1, 2, 3, and 4 were fully supported. A degree of support was found for Hypotheses 5, 7, and 9. Hypothesis 6 and 8 were not supported. In the next chapter, potential interpretations, significance, and implications of these findings are discussed.

CHAPTER V

DISCUSSION

In this chapter, a brief overview of the study is provided, major findings are presented, potential interpretations of findings are offered, and potential limitations of the study are presented. Implications of results for school counselors and school counselor educators are discussed, and recommendations for future research are provided.

Overview

The problem addressed in this study was the dearth of literature regarding crisis intervention in the schools. Although multiple nationwide studies (e.g., CDC, 2005; DeVoe et al., 2004; DeVoe et al., 2005) have delineated a significant number of individual crises that occur commonly in the schools, previous researchers had not considered important issues such as school counselor training in crisis intervention, adequacy of preparation and resources, self-perceived skills that are necessary to provide crisis intervention in the schools, and any potential relationships between school counselors' exposure to crisis, school counselors' level of training, and school counselor burnout.

In response to this need, a study was designed to assess school counselor exposure to individual crisis situations, reported crisis frequency, self-perceived crisis intervention efficacy, crisis training experiences both during and after master's level training, perceived usefulness of crisis response resources, skills necessary for successful crisis intervention as a school counselor, and comfort levels with those skills. This study

included exploration of these topics and an examination of the relationships that crisis training and crisis exposure have to reported levels of school counselor burnout. Specific goals included: (a) determining the types/frequencies of individual crises faced by school counselors; (b) describing the formal and informal training school counselors have in individual crisis intervention and stabilization; (c) ascertaining school counselors' perceptions of the adequacy of that training; (d) describing the types of resources utilized by school counselors when encountering individual crisis situations; (e) examining school counselors' perceptions of the helpfulness of those resources; (f) determining the skills that school counselors need to have in order to effectively intervene when faced with an individual crisis situation; (g) determining whether frequency of crisis intervention contributes to school counselor burnout; and (h) examining whether self-perceived crisis intervention skills, resources, and training moderate the relationship between frequency of crisis intervention and burnout levels.

A secondary purpose of this study was to determine whether the Crisis Intervention Descriptive Questionnaire (CIDQ) is appropriate for examining school counselors crisis experiences and crisis training, usefulness of resources, and perceived necessity and comfort level with identified crisis intervention skills. This study, therefore, also included preliminary investigation of the CIDQ.

Results of the study were presented in chapter four. Hypotheses 1, 2, 3, and 4 were fully supported. Partial support was found for Hypotheses 5, 7, and 9. Hypothesis 6 and 8 were not supported. In this chapter, potential interpretations, significance, and implications of these findings are discussed.

Major Findings

Hypothesis 1

Research question 1 was designed to describe and assess the exposure that professional school counselors had to twelve different types of individual crises that they might encounter. It was hypothesized that they would encounter a variety of individual crises, including suicidality, self-injurious behavior, physical and relational aggression/bullying, violence, child abuse and neglect, and severe mental health issues. Participants reported having been exposed to multiple types of individual crisis situations over their tenure as school counselors. In total, over three-quarters of participants reported having worked with nine or more of the twelve individual crises listed, with over half working with at least 11 of the 12 types of individual crises. This is consistent with the literature which suggests school counselors potentially face a range of individual crises (e.g., Collins & Collins, 2005; Sandoval, 2002). In addition, this reflects the significant amount of children and adolescents who face issues of suicide (e.g., CDC, 2005; NIMH, 2003), violence (e.g. DeVoe et al., 2005), abuse (e.g., NCCANI, 2004; 2005; Sedlak & Broadhurst, 1996), and severe mental health issues (NIMH, 2000)

Hypothesis 2

Research question 2 was designed to assess the frequency of 12 individual crises seen by participants in the previous year (12 month period). The hypothesis stated that some crises (e.g., suicidal ideation, child physical abuse) would occur more frequently than other crises (e.g., suicidal behavior, child sexual abuse). As discussed in Chapter 4, there does seem to be a difference in reported rates of the individual crises surveyed.

Additionally, multiple participants reported rates verbally (e.g., “daily,” “too many times to count, ” etc.), and these responses could not be quantified, which suggests that some of these mean incidence rates may not be fully indicative of what school counselors are seeing. There do appear to be differences in the frequency with which various individual crises are seen by counselors. The potential also exists, however, for some crises (i.e. sexual abuse, suicidal ideation, suicidal intent) to be more difficult for school counselors to detect, due to less visible symptoms or signs. Also, there seems to be a significant range within each type of crisis, which may be indicative of differences in rates of reporting by students or differences in rates of identifying students at risk by counselors.

The rates reported by participants does seem inconsistent with some of the literature available on prevalence rates of crises among children and adolescents. Specifically in addressing suicidal behavior, ideation, and intent, participants in this study seem to be reporting frequencies far below what might be expected from studies like the Youth Risk Behavior Surveillance Study (e.g., CDC 2005). A similar discrepancy appeared in a study by Mathai (2002).

Hypothesis 3

Hypothesis three was developed to explore the level of training that school counselors have around different crisis topics. It was hypothesized that school counselors would report a variety of training experiences, but that some counselors would report no training. As far as specific crisis coursework, the majority of participating school counselors reported not having any semester long crisis courses either during or after their master’s program, a finding that is consistent with the findings of Allen et al.

(2001). Participants also reported a variety of training experiences around crisis topics during their master's program, with over half of responding participants reporting training around suicidality (61.4%), child abuse and neglect (58.3%), and severe mental health issues (58.3%) during their master's coursework. Less than one-third of participants responded to having training in gang or other school violence (30.8%) or CISD (29.5%).

Informal training after masters coursework also was assessed. Over three-quarters of participants indicating some level of post-master's training in topics including suicidality (88.6%), child abuse and neglect (84.7%), bullying (83.8%), and gang or other school violence (79.8%). Training and crisis topics less frequently attended included CISD (59.8%), severe mental health issues (61.8%), and self-injurious behavior (61.8%).

These are initial findings, and there are several reasons that these results must be interpreted with caution. First, it should be noted that a substantial minority of participants left parts of the *Training Experiences* section of the CIDQ blank. The number left blank varied by training topic, but ranged between 13.3% (master's level training around issues of suicidality) and 22.2% (master's level training around bullying). It is not possible for the researcher to determine whether blank answers were indicative of participants not having training or difficulty remembering training experiences. Therefore, all percentages reported have been completed responses and may differ somewhat from the overall training levels of the school counselors sampled. Additionally, these are dichotomous scores indicating merely the presence or absence of at least one training experience during the entirety of each participants master's and/or

post-master's experience. Types of training experiences range substantially, from a single presentation to multi-day workshops and infusion into coursework. Therefore, the presence or absence of training experiences does not take into account the level of training or the number of training experiences that each participant may have had. Also, for those participants who graduated multiple years ago, it might have been difficult to remember specifically what crisis topics had been covered in their master's program or exactly which training experiences they might have had in a career that has stretched multiple decades. Therefore, responses around both master's level and post-master's training experiences must be interpreted with caution, and it should not be assumed that presence or absence of training experiences is indicative of crisis intervention skill around those particular topic areas.

In addition, several participants commented that their school systems provided extensive training experiences, so more research is necessary in order to determine whether the difference of post master's training crisis topics is due to choice (and therefore, suggests more salience to the school counselors choosing those topics) or whether they are evidence of what school districts are mandating as training experiences for their school counselors.

Hypothesis 4

Hypothesis 4 examined the perceived helpfulness of the crisis topic training experiences in which school counselors reported having participated. Participants reporting training experience(s) and the perceived helpfulness of those experience(s) seemed to indicate that, overall, those experiences were helpful. On a four-point scale,

with 1 = not helpful and 4 = very helpful, the mean helpfulness scores for each crisis topic area were all above 3.0. Training around suicidality was rated as most helpful (M = 3.27), followed by CISD (M = 3.23). Bullying (M = 3.05) and self-injurious behavior (M = 3.04) topics were rated the lowest of the seven, yet were still rated as helpful by participants. This seems to indicate that, overall, participants value training experiences on each of these crisis topic areas, and that the training that they are receiving has been helpful, overall, to them in their careers. This appears consistent with Mathai's (2002) findings that even those school counselors who had crisis training were interested in more training experiences.

As with hypothesis 3, these results must be interpreted with caution, due to the amount of missing data in the *Training Experiences* section of the CIDQ. Overall, it is impossible to determine whether the training experiences reported were those that were the most salient in participant's minds (and therefore the most—or least—helpful), or whether participants had other training experiences that went unreported.

Hypothesis 5

Hypotheses 5a and 5b concerned the use of a variety of resources that school counselors might turn to during a crisis. Although this hypothesis was exploratory in nature, in order to determine what the perceived helpfulness of a variety of crisis intervention resources were, several findings emerged. First, participants overwhelmingly noted that other on-site school counselors were the most helpful of the crisis resources listed. This may be especially salient, given that 56 participants (43.4%) reported being the sole school counselor at their site (or multiple sites, in two cases).

A second finding is that both on-site and physical resources were reported to be more useful to participants than external personnel resources, including central office personnel, community mental health personnel (including community counselors, psychologists, and psychologists), as well as school counselor educators. It may be possible, through further evaluation and discussion with practicing school counselors, to determine ways in which external personnel can be more helpful or accessible in crisis situations.

Hypothesis 6

Hypothesis 6 stated that there would be a difference among skills subsets on perceived comfort and perceived necessity. Due to a limited sample size, performing factor analyses on the skills necessity and skills comfort scales would have been statistically unsound, and, therefore, this hypothesis remains unexplored. It is notable, however, that of the three skills perceived as most necessary, all three focus on providing direct services to students, and two of the three reference suicidality and harm to self. This seems especially salient considering that participants reported more training on topics of suicidality than other topics, both in their master's program and post-master's and that training on topics of suicidality also was rated as most helpful. Clearly, intervening around issues of suicidality seems to be a perceived need for the school counselors surveyed. This seems to be in line with the number of students reporting suicidal ideation and suicidal behavior (e.g., Brener, Krug, & Simon, 2000; CDC, 2005; NIMH, 2004).

Skills reported as least necessary seemed to center around the more educational pieces of crisis intervention, including providing psychoeducation about the crisis and providing comprehensive case presentations for peers/administration. Although this study did not explore any issues related to school counselors receiving clinical supervision, it would be interesting to explore whether these ratings were lower due to being linked to experiences to education and supervision after the immediate crisis was over, and therefore, having a less immediate impact on a crisis situation. Also notable was that participants were least comfortable with providing psychoeducation about the crisis. Once again, exploration of whether this was due to time constraints during crisis situations or a lack of knowledge about what constitutes a crisis would need to be explored further.

As far as skills comfort, participants felt most comfortable consulting with school counseling peers, which seems to reiterate the importance of having a network of school counselors who can provide each other support and feedback during crisis situations. In addition, they felt comfortable with establishing rapport quickly and making CPS/DSS reports. They felt least comfortable with providing CISD, identifying indicators of sexual abuse, and providing psychoeducation about the crisis. Each of the skills participants rated as least comfortable seem to be linked to skill sets particular to crisis and crisis topics, whereas those that were rated as more comfortable seem to be more generally linked to basic counseling and consulting skills. Further exploration to determine whether school counselors are less comfortable with skills specific to crisis, as opposed to more generalized counseling skills that can be applied to crisis situations is necessary.

Hypothesis 7

Hypothesis 7 stated that there would be no difference in training, perceived usefulness of resources, perceived crisis skills necessity, or perceived crisis skills comfort based on individual or demographic factors. Although this hypothesis was partially supported, there were three significant main effects. Two of those were differences between participants reporting that they were the sole school counselor at their school and those who had at least one other part-time school counselor on-site. Those school counselors who had other school counselors at their site reported more post-master's training and a higher comfort level with crisis skills. The difference in post-master's crisis training experiences may be due to having colleagues who can rotate with them so that they could attend conferences or other training experiences. This increased training may then impact participants' perceived comfort with skills. Another possibility is that school counselors who have peers on-site have been able to more easily consult (or provide consultation) in times of crisis and therefore gained vicarious experience with crisis situations that increased their comfort level. Replication of these results with a larger sample size is warranted, due to relatively low statistical power. At the same time, it appears that respondents benefitted from having another school counselor on-site.

Hypothesis 8

Hypothesis 8 stated that burnout levels would be significantly predicted by crisis exposure and crisis frequency. Although this hypothesis was not supported, further analysis of different types of crisis situations, especially those that may be perceived as more stressful by school counselors, may be warranted. In addition, multiple participants

responded to the crisis frequency question with verbal answers that were not able to be quantified (i.e., “too many to count,” “all the time,” etc.) and, therefore, the frequencies used for analysis may not have been fully representative of the frequency of crises seen by this sample. Use of a more behaviorally-based system for tracking crises over a shorter time period might be a more accurate way to determine frequencies of crisis than dependence on self report over a longer span of time, as was used in this study.

One interesting result that emerged in analyses for hypothesis 8b was that reported frequency of physical abuse was a significant predictor of burnout level. Although no specific data were compiled on post-vention with physical abuse or contact with Child Protective Services (CPS) or the Department of Social Services (DSS), there has been some evidence that reports of child abuse from school employees often are not followed up (Sedlak & Broadhurst, 1996). It may be possible that this causes frustration for school counselors who are mandated to report child abuse and who do not see that their reports are as helpful as they might prefer. Further research into the relationship between school counselors and CPS/DSS might shed more light on this result.

Hypothesis 9

Although there did not seem to be a significant relationship between crisis exposure, crisis frequency, and level of school counselor burnout, there was partial support for hypothesis 9, in that some types of training do seem to be related to lower burnout levels in school counselors. Primarily, master’s level training on self-injurious behavior and overall training on CISD are significantly negatively related to reported school counselor burnout levels, albeit modestly. It is especially relevant that master’s

level training is related to burnout, because it addresses the idea that even years after graduation, master's level training may affect school counselors in a variety of ways. More research is needed to determine which factors make the relationship between master's level training and burnout levels stronger than the relationship between post-master's training, and to see whether it is the specific topics covered, a more skills-based approach, or even an affective component that is tied to the student role that is significantly negatively correlated to susequent burnout level.

Potential Limitations

Although precautions were taken to minimize threats to internal and external validity, there are several potential limitations of this study. Limitations include use of volunteers, the sampling plan, reliance on self-report data, length of the instrumentation, and the time of the year during which data was collected.

First, data collection was dependant on the use of volunteer participants. Those who had a specific interest in the topic may have chosen to participate more readily than those who felt uncomfortable with or did not value the topic. It is not possible to determine specific ways in which participants differed from non-participants.

Second, the sampling frame was a list of school counselors provided by the North Carolina Department of Public Instruction. Although the list was comprised of school counselors, three potential participants responded that they were social workers, not school counselors. Therefore, it is possible that there might have been participants selected randomly who were not school counselors and, accordingly, chose not to respond. In addition, due to the inclusion of school counselors employed only in one

state, it is possible that the training experiences of the participants surveyed are limited primarily to training programs in and around the state, and are not representative of training experiences provided nationwide. Further, due to the inclusion of school counselors from only one state, the findings may not be generalizable beyond the state of North Carolina.

A third limitation is the reliance on participant self-report, notably susceptible to bias (Heppner, Kivlighan, & Wampold, 1999). For example, participants might under-estimate burnout symptomology, over-estimate their comfort with crisis counseling skills, or inflate their levels of training. Additionally, the nature of some of the items, particularly those focused on training experiences, required a high level of recall. Participants may have had difficulty recalling the exact training experiences they had either during or after their master's program, particularly when multiple years had passed since their master's training. This may, in part, explain the increased level of missing data in the training section of the CIDQ.

A fourth limitation was the overall length of the instrumentation. The stapled survey booklet received by participants was 14 pages (including the cover page and the definitions page). Therefore, the sheer length of the packet may have deterred some participants from responding. The inclusion of burnout as a factor makes this a particularly salient limitation, as participants who were experiencing higher levels of burnout might have been less likely to complete a lengthy survey.

Finally, the time of year during which data was collected may have been a limitation. Surveys were distributed in mid-March, which is when many school districts

are starting to get prepared for testing, registration, and other time-sensitive tasks. Thus, the combination of timing of the survey distribution and the overall length of the survey may have impacted both the overall response rate and the likelihood that particular groups (e.g., those experiencing higher rates of burnout, high school counselors involved in testing) would decline to respond. In addition, the assessment of burnout is cross-sectional in nature, and therefore may have been particularly subject to historical bias.

In summary, use of volunteer participants, sampling procedures, self-report bias, length of instrumentation, and time of the year when data was collected are potential limitations of the current study. The data collection procedures and study methodology were developed in attempt to reduce potential sources of bias and to increase response rates from the selected sample. Although results need to be interpreted with caution around potential sources of bias and limitation, the results provide an initial look at the potential relationship between school counselors, crisis intervention, and school counselor burnout.

Implications for Counselor Education

Although this study is only an initial step in exploring the crisis and crisis training experiences of school counselors and the potential relationship that these experiences might have on burnout, there are several implications for the field of counselor education. First, the reports of exposure and frequency of the individual crisis situations examined confirms that school counselors are seeing a variety of crisis situations in the schools on a regular basis. Therefore, training future school counselors to intervene in and assess crisis situations is an important part of school counselor education.

Second, there seems to be a limited exposure to some types of crisis topics in master's level training programs. Although most of the individual crisis topics perceived as most important by participants corresponded with topics that most participants covered during their master's training, there was still a substantial minority that reported not having training on those topics. For example, approximately 30% of participants reported not having training on issues of suicidality, child abuse and neglect, and severe mental health issues, yet, these three topics were three of the four crisis topics rated as most important. In addition, although other topics were less highly ranked, all crises listed were rated has having a high level of importance, and yet topics like gang or school violence were covered in the training programs of only 31% of respondents. Also, fewer participants had CISD training than training on any other crisis topic, yet CISD training was significantly negatively correlated with burnout. One possibility is that skills-based training experiences, rather than knowledge-based experiences might provide school counselors-in-training with resources that provide a sense of efficacy or skill that serves as a protective factor against burnout. Results of this study suggest that CISD is important, if not essential , for school counselors.

Third, participants reported that school counselor educators were "slightly useful" in crisis intervention, and ranked 19th most useful on the list of 24 resources. Although school counselor educators are not responsible for providing direct support to practicing school counselors during times of crisis intervention, this may be indicative of a disconnect between the research, service, and supervisory work of school counselor educators and practicing school counselors. In order to best prepare school counselors-in-

training, there may be ways in which counselor educators can better connect with the "front line" counselors through supervision of master's level field experiences, increased encouragement and support for supervision of practicing school counselors after completion of their master's level training, research that is practically-based and easily disseminated to practicing school counselors, and increased visibility to and connection with practicing school counselors.

Implications for Counselors

There are also several implications for practicing school counselors. Primarily, this survey suggests that school counselors see a wide variety of individual crises and, therefore, are responsible for ensuring that they have the competence to handle those crises. If crisis intervention training is not specifically built into a master's program or inservice training for the school district, it falls on school counselors to ensure that they seek out the training they need, whether through seeking clinical or peer supervision, attending conference presentations or workshops, or finding consultants or other resources to provide knowledge and support in a crisis.

Another implication for school counselors is the reiteration of the importance of support. Two of the resources rated as especially helpful were other school counselors, either on-site or in other schools. This result underscores the need for an interconnected school counseling community, where school counselors can provide each other with support and also provide resources, information, training, consultation, and peer supervision. Due to the large amount of respondents who reported being the only school counselor at their school, building in methods for networking with other school

counselors, either formally or informally, may be important not only to better serve the student population, but also to reduce burnout among school counselors. Peer consultation models exist that might provide the needed structure for this to occur (e.g., Benshoff & Paisley, 1996; Borders, 1991; Crutchfield & Borders, 1997)

In terms of burnout, the mean burnout score of respondents indicated a population demonstrating warning signs of burning out (M = 26.47, SD = 9.35). In addition, approximately 20% of respondents fell into a range exhibiting burnout (n = 21, 16%) or severe burnout (n = 5; 3.8%). Although many respondents did not report high levels of burnout, the response rate of this study was low (approximately 16%), and it is possible that potential participants who were experiencing higher levels of burnout may have been less likely to respond. Even if respondents and non-respondents did not differ in terms of burnout, participants' levels of burnout on the BMS indicate a population exhibiting warning signs of burnout, consistent with the findings of previous researchers (e.g., Bacharach et al., 1986; Kesler, 1990; Lambie, 2002; Stephan, 2005), and reiterate the importance of learning more about how to best prevent or reduce burnout in this population.

One other interesting implication of this study is that while the crisis topic-based training did not appear to predict lower levels of burnout, CISD training was significantly correlated with lower burnout scores. One reason for this might be because CISD training is specific and skills based, whereas other types of training being examined in this study may have been more knowledge-based, with less readily-drawn ties to practical intervention. More research on the implications of skills-based training as a potentially

protective factor against burnout is needed in order to replicate and more fully understand this finding and the implications it may have for practicing school counselors.

A final implication for school counselors is the potential use of the CIDQ *Skills* section as a potential tool for self-assessment of comfort level with various crisis topics and skills. Such a self-assessment, either individually or within a school system, might inform continuing education needs.

Recommendations for Future Research

This study is only a first step towards better understanding the dynamics between crisis, crisis training, and school counselor burnout. First, the target population for this study only included school counselors within one state, so a replication of this study with a nationally representative sample would be important in order to accurately assess the relationships between crisis, crisis training, and burnout as they affect school counselors at the national level.

Second, all information received from this study is self-report and, therefore, is subject to bias. Content analysis of crisis courses and the inclusion of crisis topics in school counseling courses would be helpful in order to more accurately ascertain the types of training that pre-practice school counselors receive in their master's programs. For example, researchers might consider content analyses of relevent syllabi and survey school counseling interns. In addition, information on the content and types of inservice workshops offered or required by school districts would give a more diverse picture of the opportunities that school counselors have for continuing education and further training on crisis topics and crisis intervention skills. A major limitation of this study was

the amount of missing data from the *Crisis Training* section of the CIDQ. It may be that training experiences are difficult to recall after a significant time has passed. Therefore, charting training experiences on a more specific level over a shorter period of time also might be helpful to determine the level of crisis intervention or crisis topic training that school counselors are receiving.

Regarding exposure to and frequency of crisis experiences, although participants reported multiple incidences of a variety of individual crises, the reported numbers seem to underrepresent the levels of crises reported by students in nationwide surveys such as the Youth Risk Behavior Surveillance Study (CDC, 2005). It is possible that school counselors report crises at lower levels because they see them at lower levels. If this is the case, it may occur for a variety of reasons, including spending less time providing responsive services to students due to non-counseling duties (e.g., test coordination, scheduling, course registration), avoidance of crisis situations due to discomfort, or isolation from the student body due to paperwork. Therefore, there is a need for behaviorally-based research to more accurately track the frequencies of crises seen by school counselors and determine the amount of time that school counselors are spending providing direct services to students in crisis. Further, because school counselors are expected by both their national organization (e.g., ASCA, 1999; 2000a) and by future school administrators (Fitch et al., 2001) to serve students in crisis and those at risk for suicide, School counselors, therefore, must be proactive as advocates for those students. With the time constraints that school counselors often face, serving as guardians of their time as well as exploring efficient methods of serving large student bodies may be

necessary, including implementing methods of primary prevention, engaging in strategic planning with the administration about the benefits and drawbacks of some of the testing and non-counseling duties that school counselors may be required to do, and constantly updating crisis intervention skills and exploring any issues of discomfort around crisis intervention.

Another area for future research includes a more thorough exploration of skills necessary for crisis intervention, both for school counselors and for other groups of counselors. Although an initial exploratory factor analysis was uninterpretable due to the limited number of participants, there is evidence of a factor structure upon which further research may shed further light. Development of a theoretically sound instrument that assesses a set of factorally-sound crisis competencies would be an important step to help counselors better identify areas of strength and weakness in crisis intervention and pinpoint areas for further growth in order to best serve students.

Another area for future research would be to assess the level of peer and/or clinical supervision that school counselors receive regarding crisis intervention. Despite a growing amount of literature stressing the importance of clinical supervision for school counselors (Barret & Schmidt, 1986; Borders & Usher, 1992; Page, Pietrzak, & Sutton, 2001; Roberts & Borders, 1994), the proportion of school counselors who receive clinical supervision is very low (Page et al.; Sutton & Page,1994). Supervision may be a potentially important source of training for school counselors who engage in peer or clinical supervision.

Conclusion

The purpose of this study was to describe (a) the individual crises typically faced by professional school counselors, (b) the crisis training of those school counselors, and (c) any relationship that crisis and/or crisis training might have with level of school counselor burnout. This study included the exploration of multiple facets involving school counselor crisis experiences, school counselor crisis training, school counselor crisis intervention resources, school counselor crisis intervention skills, and school counselor burnout. Results indicated that school counselors reported exposure to a high number of individual crises over their career and reported multiple incidences of variety of individual crises over the previous year. They may, however, lack preparation—especially during master's level training—in how to intervene in those crisis situations. In addition, participants tended to find crisis training experiences helpful, with on-site personnel and physical resources most useful during the crisis intervention process. Crisis exposure and crisis frequency predicted a small but statistically significant portion of the variance in school counselor burnout. CISD training significantly predicted lower levels of burnout and, thus skills-based training may provide a protective factor against burnout.

In addition, this study provided an initial screening of the CIDQ, a questionnaire designed to examine the crisis experiences, training, resources, and skills used by school counselors. Study results provided a degree of promise for the development of a quantitative measure of skills necessary for crisis intervention in the schools as well as a method of quantifying the level of comfort school counselors reported having with those skills. Future research and further testing of crisis intervention skills will lead to a better

understanding of the types of skills necessary for successful crisis intervention in the schools, as well as identifying areas of comfort and discomfort with current levels of skill.

Findings of this study may be used to guide future research regarding individual crises in the schools, crisis intervention training of school counselors, and the potential relationships that crises and crisis intervention training may have on school counselor burnout. Primarily, further delineation of crisis intervention training experiences at the master's level to confirm the types of topics and training that pre-practice school counselors receive, and exploration of in-service opportunities provided by school districts will contribute to knowledge of school counselor training around individual crises. Behaviorally-based research to more accurately track the frequencies of crises that school counselors work with would be beneficial, as would further exploration and development of crisis intervention skills competencies. This, and other research into the experiences of school counselors around crisis, crisis training, and burnout, would produce needed information to help school counselors best serve their students.

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APPENDIX A

COVER LETTER AND INFORMED CONSENT FOR PILOT STUDY PHASE 1

October 10, 2005

Dear Counseling Colleague,

Hello! My name is Carrie Wachter, and I am currently conducting a study investigating crisis situations in schools, crisis intervention training of school counselors, and burnout in school counselors. I've had experience as a teacher and a school counselor in Florida and North Carolina, and I know the pressures and uncertainties that school counselors face on a daily basis. Through this research, I am hoping to identify some ways that those pressures may be alleviated.

You were selected for participation in a pre-study evaluation of the questionnaire due to your expertise in school counseling, school counselor education, or crisis counseling to ensure that it is comprehensive, so your participation in this research opportunity is crucial. *Your perspective is really needed!* This study will advance our knowledge about crisis in the schools, crisis intervention training, and burnout of North Carolina's professional school counselors. This information will provide insight into the best methods of training school counselors to deal with crisis intervention and burnout, which will affect students and the whole school climate. It also will enable researchers to examine how the rates and levels of crisis and the amount and type of crisis intervention training affect burnout in school counselors, which may have a wide-reaching impact on school counselor education and training. It also might help you identify potential resources to help or support school counselors in crisis intervention that you may not have previously identified.

For this preliminary evaluation, please look through the enclosed survey and complete the evaluation form. If you choose to complete the evaluation form, you will be asked to participate in a focus group to discuss the questionnaire and provide feedback directly to the researcher who created it. This focus group will last a maximum of one hour and refreshments will be provided. The completion time for the enclosed booklet will be approximately 45 minutes. In addition, you may fill out and bring the enclosed contact sheet if you wish to receive follow-up information on the study and/or to enter your name into a lottery in which two participants will each receive $50.00.

You have many rights as a participant of this research. First, participation is voluntary. You are free to refuse to participate or to withdraw your consent to participate in this research at any time without penalty or prejudice. Second, anonymity for each participant is highly valued. There will be no identifying information on the evaluation sheet, and in the focus group, no identifying information will be given for any comments made. No personal information will be sought from you or processed from the questionnaire itself, as the focus is solely on evaluation of the questionnaire. All information will be kept confidential, and your materials will be stored in a secured, locked facility for three years before being shredded. By filling out the forms and returning them in the enclosed envelope, I will assume you have consented to participate in this study. Please keep this letter as a copy of your rights as a participant.

This study is not expected to involve any risk of harm greater than that encountered in daily life. If you have any concerns generated by participating in this study, you may call or email the researcher to express these concerns or obtain a counseling referral. You may request a summary of results by checking the appropriate box on the booklet. If you have any questions or concerns, please do not hesitate to contact me [(336) 334-3570 or carrie.wachter@gmail.com]. My faculty advisor, Dr. Craig Cashwell, may also be contacted at cscashwe@ung.edu. For additional information about the rights of participants in research, contact Mr. Eric Allen at (336) 256-1482.

Thank you so much for your assistance and your timely response!

Sincerely,

Carrie A. Wachter, MS, NCC
Doctoral Student
The University of North Carolina at Greensboro

Consent to Participate in Focus Group

You have been selected to participate in a focus group with the purpose of evaluating an instrument designed to measure frequency and types of crises in schools, school counselor training in crisis intervention, and the types of skills school counselors identify as vital for crisis intervention. This focus group will last approximately one hour, during which you will be asked for your honest feedback about the instrumentation you received. In order to ensure that all feedback is received, the focus group will be audiotaped, however no identifying information about you will be put on the audiotape or any written descriptions of the process of the focus group. The tape and any feedback forms collected will be stored in a locked facility for a maximum of three (3) years, after which they will be destroyed by the researcher.

I, _____, agree to participate in the focus group described above. In addition, I agree to allow the focus group to be audiotaped. I understand that the tape will be kept secure in a locked facility, that the contents of the tape will be kept confidential, and that the tape will be destroyed after being kept for a time not to exceed three years.

I have read and understand my rights as a research participant, including my right to discontinue participation in the focus group process and to request discontinuation of taping at any point without any fear of negative repercussions.

_____ _____

Participant Name Participant Signature

_____ _____

Witness Name Witness Signature

APPENDIX B

SURVEY PACKET FOR PILOT STUDY PHASE TWO

January 2, 2005

Dear School Counseling Colleague,

Hello! My name is Carrie Wachter, and I am currently conducting a study investigating crisis situations in schools, crisis intervention training of school counselors, and burnout in school counselors. I've had experience as a teacher and a school counselor in Florida and North Carolina, and I know the pressures and uncertainties that school counselors face on a daily basis. Through this research, I am hoping to identify some ways that those pressures may be alleviated.

Because you were selected from the population of school counselors in North Carolina, your participation in this research opportunity is crucial. *Your perspective is really needed!* It will advance our knowledge about crisis in the schools, crisis intervention training, and burnout of North Carolina's professional school counselors. This information will provide insight into the best methods of training school counselors to deal with crisis intervention and burnout, which will affect students and the whole school climate. It also will enable researchers to examine how the rates and levels of crisis and the amount and type of crisis intervention training affect burnout in school counselors, which may have a wide-reaching impact on school counselor education and training. It also might help you identify potential resources to help or support you in crisis intervention that you may not have previously identified.

Please complete the enclosed survey and mail it back to me in the enclosed pre-addressed, postage-paid envelope. It is important that you answer all questions as honestly as possible and avoid leaving any unanswered. The completion time for the enclosed booklet will be approximately 30 minutes. In addition, you may fill out and return the enclosed contact sheet if you wish to receive follow-up information on the study and/or to enter your name into a lottery in which two participants will each receive $50.00.

You have many rights as a participant of this research. First, participation is voluntary. You are free to refuse to participate or to withdraw your consent to participate in this research at any time without penalty or prejudice. Second, anonymity for each participant is highly valued and will be maintained at all times. Please be assured that your response will be reported on a group basis only, thereby avoiding the possibility of individual identification. Numbering on the enclosed questionnaire is for follow-up purposes only. All information will be kept confidential, and your materials will be stored in a secured, locked facility for three years before being shredded. By filling out the forms and mailing them in the enclosed envelope, I will assume you have consented to participate in this study. Please keep this letter as a copy of your rights as a participant.

This study is not expected to involve any risk of harm greater than that encountered in daily life. If you have any concerns generated by participating in this study, you may call or email the researcher to express these concerns or obtain a counseling referral.You may request a summary of results by checking the appropriate box on the booklet. If you have any questions or concerns, please do not hesitate to contact me [(336) 334-3570 or carrie.wachter@gmail.com]. My faculty advisor, Dr. Craig Cashwell, may also be contacted at cscashwe@ung.edu. For additional information about the rights of participants in research, contact Mr. Eric Allen at (336) 256-1482.
Thank you so much for your assistance and your timely response!

Sincerely,

Carrie A. Wachter, MS, NCC
Doctoral Student
The University of North Carolina at Greensboro

Definitions Page

These definitions have been compiled through a review of crisis literature and the personal experiences of the researcher.

Suicidal Ideation: Having thoughts pertaining to taking one's own life

Suicidal Intent: Having thoughts pertaining to taking one's own life including a specific plan and desire to follow through on those thoughts

Suicidal Behavior: Having thoughts pertaining to taking one's own life accompanied with an action specifically meant to cause severe harm or death

Self-Injurious Behavior: Inflicting direct harm to oneself without intent to die as a result (Simeon & Favazza, 2001)

Physical Aggression/Bullying: repeated physical attacks or threats of a less powerful person by a more powerful person (Farrington, 1993)

Relational Aggression/Bullying: repeated acts or threats intended to cause a victim to feel isolated, ostracized, or shunned

Homicidal Intent: Having thoughts pertaining to taking another person's life including a specific plan and desire to follow through on those thoughts

Gang Violence: Physical attacks or threats against a person or persons by an individual or individuals involved in gang activity

Other School Violence: Physical attacks or threats that are not gang-related and do not constitute bullying. This may involve robbery, rape, assault, fighting, homicide, etc.

Physical Abuse: Any physical injury deliberately inflicted on a minor by a caretaker or individual with authority over that child. Physical abuse does not include spanking, but does include discipline that is unreasonable (i.e. punching, hitting a child with a belt or coat hanger)

Sexual Abuse: Any sexual contact of a child by an older person, including rape, molestation, prostitution, having a child watch adult sexual behavior, showing a child pornography, etc.

Neglect: the failure to provide for the child's basic physical, emotional, medical, or educational needs (NCCANI, 2005)

Severe Mental Health Issues: Any mental health concern that is impeding an individual's ability to function. This may include, but is not limited to, depressive disorders, bipolar disorders, eating disorders, psychotic disorders, and dissociative disorders.

Demographic Questionnaire

Please answer the following questions about yourself and your school:

1. Please circle your sex: (1) Female (2) Male

2. What is your age? _____

3. Which of the following best describes your ethnic group? (Circle only one number)

(1) Asian (2) Black (3) Latino
(4) Native American (5) White (6) Multiracial:
_____ (7) Other: _____

4. Please indicate your highest academic degree attained: (Circle only one number)

(1) Bachelor's (2) Master's (3) Specialist
(4) Doctoral (5) Other: _____

5. When did you receive your degree(s)?

Degree : Year received:
Degree: Year received:
Degree: Year received:

6. When you graduated from your master's program, was your program CACREP-accredited?

(1) Yes (2) No (3) Unsure

7. Is your master's degree in school counseling?

(1) Yes (2) No

8. If your master's degree is NOT in school counseling, please indicate what you received your master's degree training in. _____

9. How many years of experience do you have as a school counselor?
_____ years

10. How long have you worked in your present position? _____ years

11. Not counting yourself, how many other school counselors are on site at your school?
_____ other school counselors

12. What is your school's current student enrollment? _____ students

13. What is the percentage of ethnic minority students at your school? _____

14. What is the percentage of students at your school who receive free or reduced-price lunches? _____

15. What grades does your school serve? (Circle only one)

(1) K-5 (2) K-8 (3) 6-8
(4) 9-12 (5) Other _____

16. Please specify membership in professional organization(s). (Circle all that apply)

ACA ASCA ACES
NCCA NCSCA LPCANC
Other (please specify): _____

17. What licenses and certifications do you hold? (Circle all that apply)

NCC NCSC LPC
State counseling license _____
(Please indicate all states in which you currently hold licensure)

18. Have you ever been a teacher? (1) Yes (2) No

If yes, how many years? _____

Crisis Intervention Descriptive Questionnaire

1. Which of the following crisis situations have you encountered in your ***career*** as a school counselor?

Crisis Situation	Yes	No
Suicidal Behavior		
Suicidal Ideation		
Suicidal Intent		
Self-Injurious Behavior		
Physical Aggression/Bullying		
Relational Aggression/Bullying		
Homicidal Intent		
Gang Violence		
Other School Violence		
Physical Abuse		
Sexual Abuse		
Child Neglect		
Severe Mental Health Issues		

2. For each situation you selected, approximately how many times have you encountered that situation ***in the past 24 months (2 years)?***

Crisis Situation	Frequency (Number of Incidents)
Suicidal Behavior	
Suicidal Ideation	
Suicidal Intent	
Self-Injurious Behavior	
Physical Aggression/Bullying	
Relational Aggression/Bullying	
Homicidal Intent	
Gang Violence	
School Violence	
Physical Abuse	
Sexual Abuse	
Child Neglect	
Severe Mental Health Issues	

3. FOR YOUR MASTER'S DEGREE, did you take a semester-long course that specifically dealt with crisis and/or crisis intervention?

Yes, It was required
Yes, as an elective
No, it was offered, but I didn't take it
No, it was not offered

If you answer "No", please skip to question 5.

4. Please specify which topics were covered in your crisis and/or crisis intervention course. If a topic was covered, select Yes. If it was not covered, select No.

	Yes	No
Suicidal Behavior		
Suicidal Ideation		
Suicidal Intent		
Self-Injurious Behavior		
Physical Aggression/Bullying		
Relational Aggression/Bullying		
Homicidal Intent		
Gang Violence		
School Violence		
Physical Abuse		
Sexual Abuse		
Child Neglect		
Severe Mental Health Issues		

5. If you did not take a specific crisis intervention course during your Master's program, in which courses and/or practical experiences (e.g. internship, practicum) did you receive information about crisis intervention?

6. SINCE RECEIVING YOUR MASTER'S DEGREE, have you taken a semester-long course that specifically dealt with crisis and/or crisis intervention?

Yes, It was required
Yes, as an elective
No, it was offered, but I didn't take it
No, it was not offered

If you answer "No", please skip to question 8.

7. Please specify which topics were covered in your crisis and/or crisis intervention course. If a topic was covered, select Yes. If it was not covered, select No.

	Yes	No
Suicidal Behavior		
Suicidal Ideation		
Suicidal Intent		
Self-Injurious Behavior		
Physical Aggression/Bullying		
Relational Aggression/Bullying		
Homicidal Intent		
Gang Violence		
School Violence		
Physical Abuse		
Sexual Abuse		
Child Neglect		
Severe Mental Health Issues		

Questions 8 – 37 ask about training experiences that focus on issues of suicide, self-injury, bullying, violence, abuse, and severe mental health issues. Each of these topics has five questions that ask about training in your master's program and after your master's program.

8. FOR YOUR MASTER'S DEGREE, did you receive any training regarding dealing with issues of suicide, suicidal behavior, and/or suicidal ideation?

Yes No

9. If No, skip to question 10. If Yes, please specify what type(s) of training you received, the amount of each type of training received (approximate number of presentations attended, etc.), and how helpful you perceive that training as being in your experience as a professional school counselor.

Not Helpful 1 Slightly Helpful 2 Helpful 3 Very Helpful 4

Type of Training	Number Attended	Helpfulness
Integrated into other coursework		N/A, 1 2 3 4
Presentation/Workshop (less than 3 hours)		N/A, 1 2 3 4
Half-day workshop (3– 5 hours)		N/A, 1 2 3 4
Single day workshop (more than 5 hours)		N/A, 1 2 3 4
Multi-day workshop		N/A, 1 2 3 4
Other (please specify and rate helpfulness)		N/A, 1 2 3 4
		N/A, 1 2 3 4
		N/A, 1 2 3 4

10. SINCE RECEIVING YOUR MASTER'S DEGREE, have you received any training regarding issues dealing with suicide, suicidal behavior, and/or suicidal ideation?

Yes No

11. If No, skip to question 12. If Yes, please specify what type(s) of training you received, the amount of each type of training received (approximate number of presentations attended, etc.), and how helpful you perceive that training as being in your experience as a professional school counselor.

Not Helpful 1 | Slightly Helpful 2 | Helpful 3 | Very Helpful 4

Type of Training	Number Attended	Helpfulness
Integrated into other coursework		N/A, 1 2 3 4
Presentation/Workshop (less than 3 hours)		N/A, 1 2 3 4
Half-day workshop (3– 5 hours)		N/A, 1 2 3 4
Single day workshop (more than 5 hours)		N/A, 1 2 3 4
Multi-day workshop		N/A, 1 2 3 4
Other (please specify and rate helpfulness)		N/A, 1 2 3 4
		N/A, 1 2 3 4
		N/A, 1 2 3 4

12. Approximately when was your most recent training regarding issues dealing with suicide, suicidal behavior, and/or suicidal ideation? (Please give year)

_____

13. FOR YOUR MASTER'S DEGREE, did you receive any training regarding issues dealing with self injurious behavior or self mutilation?

Yes No

14. If No, skip to question 15. If Yes, please specify what type(s) of training you received, the amount of each type of training received (approximate number of presentations attended, etc.), and how helpful you perceive that training as being in your experience as a professional school counselor.

Not Helpful 1 | Slightly Helpful 2 | Helpful 3 | Very Helpful 4

Type of Training	Number Attended	Helpfulness
Integrated into other coursework		N/A, 1 2 3 4
Presentation/Workshop (less than 3 hours)		N/A, 1 2 3 4
Half-day workshop (3– 5 hours)		N/A, 1 2 3 4
Single day workshop (more than 5 hours)		N/A, 1 2 3 4
Multi-day workshop		N/A, 1 2 3 4
Other (please specify and rate helpfulness)		N/A, 1 2 3 4
		N/A, 1 2 3 4
		N/A, 1 2 3 4

15. SINCE RECEIVING YOUR MASTER'S DEGREE, have you received any training regarding issues of self injurious behavior and/or self-mutilation?

Yes No

16. If No, skip to question 17. If Yes, please specify what type(s) of training you received, the amount of each type of training received (approximate number of presentations attended, etc.), and how helpful you perceive that training as being in your experience as a professional school counselor.

Not Helpful 1 | Slightly Helpful 2 | Helpful 3 | Very Helpful 4

Type of Training	Number Attended	Helpfulness
Integrated into other coursework		N/A, 1 2 3 4
Presentation/Workshop (less than 3 hours)		N/A, 1 2 3 4
Half-day workshop (3– 5 hours)		N/A, 1 2 3 4
Single day workshop (more than 5 hours)		N/A, 1 2 3 4
Multi-day workshop		N/A, 1 2 3 4
Other (please specify and rate helpfulness)		N/A, 1 2 3 4
		N/A, 1 2 3 4
		N/A, 1 2 3 4

17. Approximately when was your most recent training regarding issues dealing with self injurious behavior or self-mutilation? (Please give year)

_____

18. FOR YOUR MASTER'S DEGREE, did you receive any training regarding dealing with issues of physical and/or relational bullying?

Yes No

19. If No, skip to question 20. If Yes, please specify what type(s) of training you received, the amount of each type of training received (approximate number of presentations attended, etc.), and how helpful you perceive that training as being in your experience as a professional school counselor.

Not Helpful 1 | Slightly Helpful 2 | Helpful 3 | Very Helpful 4

Type of Training	Number Attended	Helpfulness
Integrated into other coursework		N/A, 1 2 3 4
Presentation/Workshop (less than 3 hours)		N/A, 1 2 3 4
Half-day workshop (3– 5 hours)		N/A, 1 2 3 4
Single day workshop (more than 5 hours)		N/A, 1 2 3 4
Multi-day workshop		N/A, 1 2 3 4
Other (please specify and rate helpfulness)		N/A, 1 2 3 4
		N/A, 1 2 3 4
		N/A, 1 2 3 4

20. SINCE RECEIVING YOUR MASTER'S DEGREE, have you received any training regarding issues dealing with physical and/or relational bullying?

Yes No

21. If No, skip to question 22. If Yes, please specify what type(s) of training you received, the amount of each type of training received (approximate number of presentations attended, etc.), and how helpful you perceive that training as being in your experience as a professional school counselor.

Not Helpful 1 | Slightly Helpful 2 | Helpful 3 | Very Helpful 4

Type of Training	Number Attended	Helpfulness
Integrated into other coursework		N/A, 1 2 3 4
Presentation/Workshop (less than 3 hours)		N/A, 1 2 3 4
Half-day workshop (3– 5 hours)		N/A, 1 2 3 4
Single day workshop (more than 5 hours)		N/A, 1 2 3 4
Multi-day workshop		N/A, 1 2 3 4
Other (please specify and rate helpfulness)		N/A, 1 2 3 4
		N/A, 1 2 3 4
		N/A, 1 2 3 4

22. Approximately when was your most recent training regarding issues dealing with physical and/or relational bullying? (Please give year)

_____

23. FOR YOUR MASTER'S DEGREE, did you receive any training regarding dealing with issues of gang violence or other school violence (not including bullying behavior)?

Yes No

24. If No, skip to question 25. If Yes, please specify what type(s) of training you received, the amount of each type of training received (approximate number of presentations attended, etc.), and how helpful you perceive that training as being in your experience as a professional school counselor.

Not Helpful 1 | Slightly Helpful 2 | Helpful 3 | Very Helpful 4

Type of Training	Number Attended	Helpfulness
Integrated into other coursework		N/A, 1 2 3 4
Presentation/Workshop (less than 3 hours)		N/A, 1 2 3 4
Half-day workshop (3– 5 hours)		N/A, 1 2 3 4
Single day workshop (more than 5 hours)		N/A, 1 2 3 4
Multi-day workshop		N/A, 1 2 3 4
Other (please specify and rate helpfulness)		N/A, 1 2 3 4
		N/A, 1 2 3 4
		N/A, 1 2 3 4

25. SINCE RECEIVING YOUR MASTER'S DEGREE, have you received any training regarding issues of gang violence or other school violence (not including bullying behavior)?

Yes No

26. If No, skip to question 27. If Yes, please specify what type(s) of training you received, the amount of each type of training received (approximate number of presentations attended, etc.), and how helpful you perceive that training as being in your experience as a professional school counselor.

Not Helpful 1 | Slightly Helpful 2 | Helpful 3 | Very Helpful 4

Type of Training	Number Attended	Helpfulness
Integrated into other coursework		N/A, 1 2 3 4
Presentation/Workshop (less than 3 hours)		N/A, 1 2 3 4
Half-day workshop (3– 5 hours)		N/A, 1 2 3 4
Single day workshop (more than 5 hours)		N/A, 1 2 3 4
Multi-day workshop		N/A, 1 2 3 4
Other (please specify and rate helpfulness)		N/A, 1 2 3 4
		N/A, 1 2 3 4
		N/A, 1 2 3 4

27. Approximately when was your most recent training regarding issues dealing with gang violence or other school violence (not including bullying)? (Please give year)

_____

28. FOR YOUR MASTER'S DEGREE, did you receive any training regarding dealing with issues of child abuse or neglect?

Yes No

29. If No, skip to question 30. If Yes, please specify what type(s) of training you received, the amount of each type of training received (approximate number of presentations attended, etc.), and how helpful you perceive that training as being in your experience as a professional school counselor.

Not Helpful 1 | Slightly Helpful 2 | Helpful 3 | Very Helpful 4

Type of Training	Number Attended	Helpfulness
Integrated into other coursework		N/A, 1 2 3 4
Presentation/Workshop (less than 3 hours)		N/A, 1 2 3 4
Half-day workshop (3– 5 hours)		N/A, 1 2 3 4
Single day workshop (more than 5 hours)		N/A, 1 2 3 4
Multi-day workshop		N/A, 1 2 3 4
Other (please specify and rate helpfulness)		N/A, 1 2 3 4
		N/A, 1 2 3 4
		N/A, 1 2 3 4

30. SINCE RECEIVING YOUR MASTER'S DEGREE, have you received any training regarding issues of child abuse or neglect?

Yes No

31. If No, skip to question 32. If Yes, please specify what type(s) of training you received, the amount of each type of training received (approximate number of presentations attended, etc.), and how helpful you perceive that training as being in your experience as a professional school counselor.

Not Helpful 1 | Slightly Helpful 2 | Helpful 3 | Very Helpful 4

Type of Training	Number Attended	Helpfulness
Integrated into other coursework		N/A, 1 2 3 4
Presentation/Workshop (less than 3 hours)		N/A, 1 2 3 4
Half-day workshop (3– 5 hours)		N/A, 1 2 3 4
Single day workshop (more than 5 hours)		N/A, 1 2 3 4
Multi-day workshop		N/A, 1 2 3 4
Other (please specify and rate helpfulness)		N/A, 1 2 3 4
		N/A, 1 2 3 4
		N/A, 1 2 3 4

32. Approximately when was your most recent training regarding issues dealing with the physical or sexual abuse of a child? (Please give year)

_____

33. FOR YOUR MASTER'S DEGREE, did you receive any training regarding dealing with severe mental health issues?

Yes No

34. If No, skip to question 35. If Yes, please specify what type(s) of training you received, the amount of each type of training received (approximate number of presentations attended, etc.), and how helpful you perceive that training as being in your experience as a professional school counselor.

Not Helpful 1 | Slightly Helpful 2 | Helpful 3 | Very Helpful 4

Type of Training	Number Attended	Helpfulness
Integrated into other coursework		N/A, 1 2 3 4
Presentation/Workshop (less than 3 hours)		N/A, 1 2 3 4
Half-day workshop (3– 5 hours)		N/A, 1 2 3 4
Single day workshop (more than 5 hours)		N/A, 1 2 3 4
Multi-day workshop		N/A, 1 2 3 4
Other (please specify and rate helpfulness)		N/A, 1 2 3 4
		N/A, 1 2 3 4
		N/A, 1 2 3 4

35. SINCE RECEIVING YOUR MASTER'S DEGREE, have you received any training regarding severe mental health issues?

Yes No

36. If No, skip to question 37. If Yes, please specify what type(s) of training you received, the amount of each type of training received (approximate number of presentations attended, etc.), and how helpful you perceive that training as being in your experience as a professional school counselor.

Not Helpful	Slightly Helpful	Helpful	Very Helpful
1	2	3	4

Type of Training	Number Attended	Helpfulness
Integrated into other coursework		N/A, 1 2 3 4
Presentation/Workshop (less than 3 hours)		N/A, 1 2 3 4
Half-day workshop (3– 5 hours)		N/A, 1 2 3 4
Single day workshop (more than 5 hours)		N/A, 1 2 3 4
Multi-day workshop		N/A, 1 2 3 4
Other (please specify and rate helpfulness)		N/A, 1 2 3 4
		N/A, 1 2 3 4
		N/A, 1 2 3 4

37. Approximately when was your most recent training regarding issues dealing with severe mental health issues? (Please give year)

_____

For questions 38 – 41, please use the following scale:

Not Useful	Slightly Useful	Useful	Very Useful
1	2	3	4

38. For each of the following PHYSICAL resources below that may support you in the crisis intervention process, please indicate the usefulness of each resource in helping and/or supporting you in the crisis intervention process.

Not Useful 1 | Slightly Useful 2 | Useful 3 | Very Useful 4

Physical Resources	N/A	1	2	3	4
Textbooks	N/A	1	2	3	4
Journal articles	N/A	1	2	3	4
Websites	N/A	1	2	3	4
Crisis Intervention Manuals	N/A	1	2	3	4
District Crisis Plan	N/A	1	2	3	4
Other (Please specify and rate usefulness)	N/A	1	2	3	4
	N/A	1	2	3	4
	N/A	1	2	3	4
	N/A	1	2	3	4
	N/A	1	2	3	4

39. If there are any physical resources you have found particularly helpful (i.e. specific textbooks, websites, journals, etc.) please list them below.

40. For each of the following IN-HOUSE PERSONNEL resources below that may support you in the crisis intervention process, please indicate the usefulness of each resource in helping and/or supporting you in the crisis intervention process.

Not Useful 1 | Slightly Useful 2 | Useful 3 | Very Useful 4

IN-HOUSE PERSONNEL	N/A	1	2	3	4
Other Counselors at your School	N/A	1	2	3	4
Assistant Principal(s)	N/A	1	2	3	4
Principal	N/A	1	2	3	4
School Social Worker	N/A	1	2	3	4
School Nurse	N/A	1	2	3	4
School Psychiatrist	N/A	1	2	3	4
School Psychologist	N/A	1	2	3	4
Teachers	N/A	1	2	3	4
Teachers of Exceptional Students	N/A	1	2	3	4
Student Resource Officer (SRO)	N/A	1	2	3	4
Other (Please specify and rate usefulness)	N/A	1	2	3	4
	N/A	1	2	3	4
	N/A	1	2	3	4
	N/A	1	2	3	4

41. For each of the following EXTERNAL PERSONNEL resources below that may support you in the crisis intervention process, please indicate the usefulness of each resource in helping and/or supporting you in the crisis intervention process.

Not Useful 1 | Slightly Useful 2 | Useful 3 | Very Useful 4

EXTERNAL PERSONNEL	N/A	1	2	3	4
Director of Student Services	N/A	1	2	3	4
Central Office Personnel	N/A	1	2	3	4
School counselors at Other Schools	N/A	1	2	3	4
Community Counselors	N/A	1	2	3	4
Psychologists	N/A	1	2	3	4
Psychiatrists	N/A	1	2	3	4
School Counselor Educators	N/A	1	2	3	4
Hotline/Crisis Phone Specialists	N/A	1	2	3	4
Law Enforment (besides SROs)	N/A	1	2	3	4
Magistrate	N/A	1	2	3	4
Other (Please specify and rate usefulness)	N/A	1	2	3	4
	N/A	1	2	3	4
	N/A	1	2	3	4
	N/A	1	2	3	4

42. Understanding that it would be impossible to perform each of these tasks in a typical workday, please rate the following:

a). How necessary it is for school counselors to have the following skills in order to effectively intervene in crisis situations?

Unnecessary 1 Somewhat Necessary 2 Necessary 3 Vital 4

b). How comfortable you are in performing the following skills?

Not at all 1 Somewhat Comfortable 2 Comfortable 3 Very Comfortable 4

For example, if you think that the ability to hop on one leg is necessary and you feel somewhat comfortable hopping on one leg, you would answer the question as follows

The ability to…	Necessity				Comfort			
Hop on one leg	1	2	(3)	4	1	(2)	3	4

Necessity Scale: Unnecessary 1 Somewhat Necessary 2 Necessary 3 Vital 4

Comfort Scale: Not at all 1 Somewhat Comfortable 2 Comfortable 3 Very Comfortable 4

The ability to…	Necessity				Comfort			
Quickly establish a rapport with a student	1	2	3	4	1	2	3	4
Identify the precipitating event (stressor) and the student's reactions to it	1	2	3	4	1	2	3	4
Identify a history of the student's usual coping skills	1	2	3	4	1	2	3	4
Facilitate the student's expression of emotions	1	2	3	4	1	2	3	4
Normalize the student's emotional reactions to the event, when appropriate	1	2	3	4	1	2	3	4
Focus counseling on the precipitating event	1	2	3	4	1	2	3	4
Provide support to the student	1	2	3	4	1	2	3	4
Provide support to those close to the student	1	2	3	4	1	2	3	4
Actively listen to the student	1	2	3	4	1	2	3	4
Provide psychoeducation about the crisis	1	2	3	4	1	2	3	4
Help the student develop adaptive coping skills and identify additional sources of support	1	2	3	4	1	2	3	4
Establish achievable goals with the student	1	2	3	4	1	2	3	4

Necessity Scale: Unnecessary 1 Somewhat Necessary 2 Necessary 3 Vital 4

Comfort Scale: Not at all 1 Somewhat Comfortable 2 Comfortable 3 Very Comfortable 4

The ability to…	Necessity				Comfort			
Quickly consult with parents and friends of the student in order to gather any additional information	1	2	3	4	1	2	3	4
Identify presence of gangs on campus	1	2	3	4	1	2	3	4
Identify relational bullying behaviors	1	2	3	4	1	2	3	4
Intervene in relational bullying behaviors	1	2	3	4	1	2	3	4
Identify physical bullying behaviors	1	2	3	4	1	2	3	4
Intervene in physical bullying behaviors	1	2	3	4	1	2	3	4
Identify students exhibiting indicators of common mental health problems (e.g., adjustment disorders, mood disorders, anxiety disorders, ADHD)	1	2	3	4	1	2	3	4
Identify students exhibiting indicators of severe mental health issues? (e.g., bipoloar disorder, psychotic disorders, conduct disorder…)	1	2	3	4	1	2	3	4
Identify students exhibiting indicators of suicidal ideation and suicidal intent	1	2	3	4	1	2	3	4
Identify students exhibiting indicators of homicidal ideation/violence	1	2	3	4	1	2	3	4
Identify students exhibiting indicators of psychosis	1	2	3	4	1	2	3	4
Identify students exhibiting indicators of sexual abuse	1	2	3	4	1	2	3	4
Identify students exhibiting indicators of physical abuse	1	2	3	4	1	2	3	4
Conduct a thorough risk assessment including relevant history, precipitating events, current status (presence of ideation, plan, etc.), and current mental status exam	1	2	3	4	1	2	3	4
Demonstrate de-escalation skills (e.g. calming, reduction of anxiety, reduction of agitation, etc.)	1	2	3	4	1	2	3	4
Demonstrate appropriate interviewing skills	1	2	3	4	1	2	3	4
Explain school crisis plan to students	1	2	3	4	1	2	3	4
Explain school crisis plan to parents	1	2	3	4	1	2	3	4
Explain school crisis plan to members of the community	1	2	3	4	1	2	3	4

Necessity Scale: Unnecessary 1 Somewhat Necessary 2 Necessary 3 Vital 4

Comfort Scale: Not at all 1 Somewhat Comfortable 2 Comfortable 3 Very Comfortable 4

The ability to…	Necessity				Comfort			
Implement school crisis plan in instances of suicide, suicidal behavior, and/or suicidal ideation	1	2	3	4	1	2	3	4
Implement school crisis plan in instances of self-injurious behavior and/or self-mutilation	1	2	3	4	1	2	3	4
Implement school crisis plan in instances of physical and/or relational bullying	1	2	3	4	1	2	3	4
Implement school crisis plan in instances of gang violence or other school violence (not including bullying)	1	2	3	4	1	2	3	4
Implement school crisis plan in instances of child abuse or neglect	1	2	3	4	1	2	3	4
Implement school crisis plan in instances of severe mental health issues	1	2	3	4	1	2	3	4
Identify ethical dilemmas or challenges related to school crisis plan	1	2	3	4	1	2	3	4
Make ethical decisions related to school crisis	1	2	3	4	1	2	3	4
Identify people who may need debriefing after a crisis	1	2	3	4	1	2	3	4
Make referrals to appropriate levels of care in the community (i.e. outpatient, intensive outpatient, inpatient)	1	2	3	4	1	2	3	4
Create a nonjudgmental environment for crisis intervention	1	2	3	4	1	2	3	4
Appropriately document concerns and procedures	1	2	3	4	1	2	3	4
Make DSS/CPS reports	1	2	3	4	1	2	3	4
Provide comprehensive case presentation for peers/administrators	1	2	3	4	1	2	3	4
Self-monitor personal reactions	1	2	3	4	1	2	3	4
Implement adaptive self-care behavior during crisis intervention and postvention	1	2	3	4	1	2	3	4
Distinguish self-injurious behavior from suicidal behavior	1	2	3	4	1	2	3	4
Communicate with other mental health providers using DSM language	1	2	3	4	1	2	3	4
Identify parties who may need follow-up services after a crisis	1	2	3	4	1	2	3	4

Necessity Scale: Unnecessary 1 Somewhat Necessary 2 Necessary 3 Vital 4

Comfort Scale: Not at all 1 Somewhat Comfortable 2 Comfortable 3 Very Comfortable 4

The ability to…	Necessity				Comfort			
Provide appropriate follow-up services after a crisis	1	2	3	4	1	2	3	4
Make decisions about breaking vs. maintaining confidentiality	1	2	3	4	1	2	3	4
Identify people who might need crisis intervention	1	2	3	4	1	2	3	4
Provide services to clients who are in crisis	1	2	3	4	1	2	3	4
Identify pertinent data for inclusion in reports	1	2	3	4	1	2	3	4
Write summaries of assessment and other supporting data for documentation	1	2	3	4	1	2	3	4
Develop a crisis prevention program	1	2	3	4	1	2	3	4
Coordinate implementation of a crisis prevention program	1	2	3	4	1	2	3	4
Evaluate mental status and assess potential causes for diminished mental health status	1	2	3	4	1	2	3	4
Assess potential danger to self and others	1	2	3	4	1	2	3	4
Evaluate the potential for a medical emergency	1	2	3	4	1	2	3	4
Evaluate the potential for a behavioral emergency	1	2	3	4	1	2	3	4
Work independently, utilizing technology to communicate and facilitate interaction	1	2	3	4	1	2	3	4
Use therapeutic, mediation, negotiation, anger management and conflict resolution skills to handle difficult situations	1	2	3	4	1	2	3	4
Explain community resources and procedures to students (for example – in cases needing involuntary commitment, referral to other levels of care)	1	2	3	4	1	2	3	4
Explain community resources and procedures to parents/guardians (for example – in cases needing involuntary commitment, referral to other levels of care)	1	2	3	4	1	2	3	4
Initiate procedures to involve others (e.g., school resource officer, special education teacher) who may assist during crisis incident	1	2	3	4	1	2	3	4

Necessity Scale: Unnecessary 1 Somewhat Necessary 2 Necessary 3 Vital 4

Comfort Scale: Not at all 1 Somewhat Comfortable 2 Comfortable 3 Very Comfortable 4

The ability to…	Necessity	Comfort
Initiate procedures to keep a student safe during crisis intervention (e.g., appropriate supervision of student expressing suicidal ideation, homicidal ideation)	1 2 3 4	1 2 3 4
Use understanding of benefits and risks associated with no-harm contracts to initiate appropriate plans	1 2 3 4	1 2 3 4
Initiate contact with parents of student(s) in crisis	1 2 3 4	1 2 3 4
Consult with school counseling peers in managing crisis situation	1 2 3 4	1 2 3 4
Seek supervision in managing crisis situation? Consult with administration in managing a crisis situation	1 2 3 4	1 2 3 4
Other (please specify and rate necessity)	1 2 3 4	1 2 3 4
	1 2 3 4	1 2 3 4
	1 2 3 4	1 2 3 4
	1 2 3 4	1 2 3 4
	1 2 3 4	1 2 3 4
	1 2 3 4	1 2 3 4
	1 2 3 4	1 2 3 4
	1 2 3 4	1 2 3 4
	1 2 3 4	1 2 3 4
	1 2 3 4	1 2 3 4
	1 2 3 4	1 2 3 4

43. Please take a moment to describe any reactions you might have had while responding to the above list of skills.

Burnout Measure: Short Version
(Malach-Pines, 2005)

Please use the following scale to answer the question: When you think about your work overall, how often do you feel the following?

1 never	2 almost never	3 rarely	4 sometimes	5 often	6 very often	7 always
Tired	1	2	3	4	5	6	7
Disappointed with people	1	2	3	4	5	6	7
Hopeless	1	2	3	4	5	6	7
Trapped	1	2	3	4	5	6	7
Helpless	1	2	3	4	5	6	7
Depressed	1	2	3	4	5	6	7
Physically weak/Sickly	1	2	3	4	5	6	7
Worthless/Like a failure	1	2	3	4	5	6	7
Difficulties sleeping	1	2	3	4	5	6	7
“I’ve had it”	1	2	3	4	5	6	7

Pilot Study Evaluation Form

Please take a few moments to complete and evaluation of this questionnaire. Your responses will be used to modify the instrument before it is used in a larger study.

Were any parts of the directions unclear? If so, please provide details or suggestions for improvement.

Did you have any problems with the wording on this survey? If so, which items were unclear?

Did you think that the survey left out any important questions?

How easy was this instrument to complete? If it was difficult, what would have made this instrument easier to complete?

How long did it take to complete this questionnaire?

Is there anything else the researcher should know regarding your experience participating in
the study?

Contact Sheet

Participant Name: _____

Participant Address: _____

_____

Participant Phone Number: _____

Participant E-Mail Address: _____

Would you like a summary of research findings?

☐ Yes ☐ No

Would you be willing to be contacted at some point in the future as a follow-up to this study?

☐ Yes ☐ No

APPENDIX C

PILOT STUDY SKILL NECESSITY AND SKILL COMFORT RATINGS

Skill	*Necessity*		*Comfort*	
	M	*SD*	*M*	*SD*
Quickly establish a rapport with a student	3.86	.38	3.71	.49
Identify the precipitating event (stressor) and the student's reactions to it	3.57	.79	3.14	.69
Identify a history of the student's usual coping skills	3.57	.79	3.00	.58
Facilitate the student's expression of emotions	3.43	.79	2.86	1.07
Normalize the student's emotional reactions to the event, when appropriate	3.43	.53	3.43	.79
Focus counseling on the precipitating event	3.00	1.00	3.14	1.07
Provide support to the student	4.00	.00	4.00	.00
Provide support to those close to the student	3.14	.90	3.71	.49
Actively listen to the student	4.00	.00	4.00	.00
Provide psychoeducation about the crisis	3.00	.58	2.86	.69
Help the student develop adaptive coping skills and identify additional sources of support	3.86	.38	3.86	.38
Establish achievable goals with the student	3.57	.53	3.57	.53
Quickly consult with parents and friends of the student in order to gather any additional information	3.57	.79	3.57	.53
Identify presence of gangs on campus	2.86	.69	1.71	.76
Identify relational bullying behaviors	3.29	.49	3.00	.58
Intervene in relational bullying behaviors	3.43	.53	3.00	1.15
Identify physical bullying behaviors	3.43	.53	3.00	.82
Intervene in physical bullying behaviors	3.29	.76	2.57	.98

Identify students exhibiting indicators of common mental health problems (e.g., adjustment disorders, mood disorders, anxiety disorders, ADHD)	3.29	.49	3.33	.47
Identify students exhibiting indicators of severe mental health issues? (e.g., bipoloar disorder, psychotic disorders, conduct disorder…)	3.33	.47	2.83	.69
Identify students exhibiting indicators of suicidal ideation and suicidal intent	3.57	.53	3.29	.76
Identify students exhibiting indicators of homicidal ideation/violence	3.71	.49	2.86	.69
Identify students exhibiting indicators of psychosis	3.71	.49	2.71	.76
Identify students exhibiting indicators of sexual abuse	3.86	.38	3.00	.82
Identify students exhibiting indicators of physical abuse	3.86	.38	3.14	.90
Conduct a thorough risk assessment including relevant history, precipitating events, current status (presence of ideation, plan, etc.), and current mental status exam	3.14	1.07	2.71	1.11
Demonstrate de-escalation skills (e.g. calming, reduction of anxiety, reduction of agitation, etc.)	3.43	.53	3.29	.76
Demonstrate appropriate interviewing skills	3.43	.53	3.29	.76
Explain school crisis plan to students	3.14	.90	2.57	.98
Explain school crisis plan to parents	3.14	.90	2.57	.98
Explain school crisis plan to members of the community	2.57	.79	2.29	.76
Implement school crisis plan in instances of suicide, suicidal behavior, and/or suicidal ideation	4.00	.00	3.00	1.15
Implement school crisis plan in instances of self-injurious behavior and/or self-mutilation	3.43	.79	2.86	1.07
Implement school crisis plan in instances of physical and/or relational bullying	3.00	.82	3.14	1.07
Implement school crisis plan in instances of gang violence or other school violence (not including bullying)	3.43	.53	2.29	1.11

Implement school crisis plan in instances of child abuse or neglect	4.00	.00	3.43	.98
Implement school crisis plan in instances of severe mental health issues	3.71	.49	3.00	.82
Identify ethical dilemmas or challenges related to school crisis plan	3.29	.76	2.57	.98
Make ethical decisions related to school crisis	3.57	.53	3.14	.90
Identify people who may need debriefing after a crisis	3.43	.53	3.29	.76
Make referrals to appropriate levels of care in the community (i.e. outpatient, intensive outpatient, inpatient)	3.71	.76	3.29	.76
Create a nonjudgmental environment for crisis intervention	3.71	.49	3.57	.79
Appropriately document concerns and procedures	3.57	.53	3.29	.49
Make DSS/CPS reports	3.57	.79	3.43	.98
Provide comprehensive case presentation for peers/administrators	2.71	.95	2.43	.79
Self-monitor personal reactions	3.43	.79	3.43	.79
Implement adaptive self-care behavior during crisis intervention and postvention	3.43	.79	3.43	.79
Distinguish self-injurious behavior from suicidal behavior	3.71	.49	3.29	.49
Communicate with other mental health providers using DSM language	2.86	.90	2.86	.90
Identify parties who may need follow-up services after a crisis	3.43	.53	3.57	.53
Provide appropriate follow-up services after a crisis	3.57	.53	3.43	.53
Make decisions about breaking vs. maintaining confidentiality	3.86	.38	3.14	.90
Identify people who might need crisis intervention	3.43	.53	3.29	.49
Provide services to clients who are in crisis	3.71	.49	3.57	.53
Identify pertinent data for inclusion in reports	2.86	.69	2.86	.69
Write summaries of assessment and other supporting data for documentation	2.71	1.11	2.86	.69

Develop a crisis prevention program	3.29	.49	2.71	.76
Coordinate implementation of a crisis prevention program	3.29	.49	2.71	.76
Evaluate mental status and assess potential causes for diminished mental health status	3.29	.49	2.57	.79
Assess potential danger to self and others	3.71	.49	3.43	.53
Evaluate the potential for a medical emergency	3.50	.76	2.86	.69
Evaluate the potential for a behavioral emergency	3.57	.53	3.00	.00
Work independently, utilizing technology to communicate and facilitate interaction	2.86	.90	2.86	1.21
Use therapeutic, mediation, negotiation, anger management and conflict resolution skills to handle difficult situations	3.43	.53	3.14	.69
Explain community resources and procedures to students (for example – in cases needing involuntary commitment, referral to other levels of care)	3.14	.69	3.14	.69
Explain community resources and procedures to parents/guardians (for example – in cases needing involuntary commitment, referral to other levels of care)	3.29	.76	3.29	.76
Initiate procedures to involve others (e.g., school resource officer, special education teacher) who may assist during crisis incident	3.57	.53	3.71	.49
Initiate procedures to keep a student safe during crisis intervention (e.g., appropriate supervision of student expressing suicidal ideation, homicidal ideation)	3.86	.38	3.86	.38
Use understanding of benefits and risks associated with no-harm contracts to initiate appropriate plans	2.57	.79	2.71	.76
Initiate contact with parents of student(s) in crisis	4.00	.00	3.86	.38
Consult with school counseling peers in managing crisis situation	3.86	.38	4.00	.00
Seek supervision in managing crisis situation/Consult with administration in managing a crisis situation	3.86	.38	4.00	.00

APPENDIX D

INSTITUTIONAL REVIEW BOARD APPROVAL PAGES

11/2/2005

THE UNIVERSITY OF NORTH CAROLINA

GREENSBORO

IRB File NUM:

056105

TITLE: Crisis in the schools: Crisis, crisis intervention training, and school counselor burnout

PI: Wachter,Carrie **DEPT:** CED

CO_PIS:

FACULTY SPONSOR: Cashwell,Craig

Action Taken:

✓ eXempt from Full Review

_____ Expedited Review

_____ Full IRB Review

Disposition of Application:

✓ Approved

_____ Disapproved

MODIFICATIONS AND COMMENTS:

IRB Chair/Designee

APPROVAL DATE*: 11/4/05

EXPIRATION DATE*: 11/4/06

NOV 07 2005

*Approval of Research is for up to **ONE** year only. If your research extends beyond one year, the project must be reviewed before the expiration date prior to continuation.

N:\RSS\apps\uncg\DATA\ORC\facesheet.rpt

APPENDIX E

SOLICITATION MATERIALS FOR MAIN STUDY

Informed Consent

March 6, 2006

Dear School Counseling Colleague,

Hello! My name is Carrie Wachter, and I am currently conducting a study investigating crisis situations in schools, crisis intervention training of school counselors, and burnout in school counselors. I've had experience as a teacher and a school counselor in Florida and North Carolina, and I know the pressures and uncertainties that school counselors face on a daily basis. Through this research, I am hoping to identify some ways that those pressures may be alleviated.

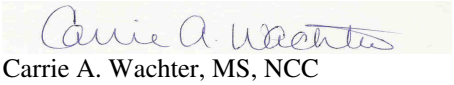
Because you were selected from the population of school counselors in North Carolina, your participation in this research opportunity is crucial. *Your perspective is really needed!* It will advance our knowledge about crisis in the schools, crisis intervention training, and burnout of North Carolina's professional school counselors. This information will provide insight into the best methods of training school counselors to deal with crisis intervention and burnout, which will affect students and the whole school climate. It also will enable researchers to examine how the rates and levels of crisis and the amount and type of crisis intervention training affect burnout in school counselors, which may have a wide-reaching impact on school counselor education and training. It also might help you identify potential resources to help or support you in crisis intervention that you may not have previously identified.

Please complete the enclosed survey and mail it back to me in the enclosed pre-addressed, postage-paid envelope. It is important that you answer all questions as honestly as possible and avoid leaving any unanswered. The completion time for the enclosed booklet will be approximately 30 minutes. In addition, you may fill out and return the enclosed contact sheet if you wish to receive follow-up information on the study and/or to enter your name into a lottery in which two participants will each receive $50.00.

You have many rights as a participant of this research. First, participation is voluntary. You are free to refuse to participate or to withdraw your consent to participate in this research at any time without penalty or prejudice. Second, anonymity for each participant is highly valued and will be maintained at all times. Please be assured that your response will be reported on a group basis only, thereby avoiding the possibility of individual identification. Numbering on the enclosed questionnaire is for follow-up purposes only. All information will be kept confidential, and your materials will be stored in a secured, locked facility for three years before being shredded. By filling out the forms and mailing them in the enclosed envelope, I will assume you have consented to participate in this study. Please keep this letter as a copy of your rights as a participant.

This study is not expected to involve any risk of harm greater than that encountered in daily life. If you have any concerns generated by participating in this study, you may call or email the researcher to express these concerns or obtain a counseling referral.You may request a summary of results by checking the appropriate box on the booklet. If you have any questions or concerns, please do not hesitate to contact me [(336) 334-3570 or carrie.wachter@gmail.com]. My faculty advisor, Dr. Craig Cashwell, may also be contacted at cscashwe@ung.edu. For additional information about the rights of participants in research, contact Mr. Eric Allen at (336) 256-1482.
Thank you so much for your assistance and your timely response!

Sincerely,



Carrie A. Wachter, MS, NCC
Doctoral Student
The University of North Carolina at Greensboro

Post Card #1

Dear School Counseling Colleague,

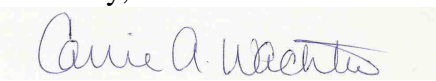
Hello! Within the past ten days, you should have received a survey packet developed to help investigate crisis situations in schools, crisis intervention training of school counselors, and burnout in school counselors. At this point, I have not yet received your response.

Because you were selected from the population of school counselors in North Carolina, your participation in this research opportunity is crucial. *Your perspective is really needed!* In addition, if you complete the survey and return the contact sheet, you will be entered in a drawing for one of two $50 incentives

Thank you so much for your time and your participation. If you have any questions or concerns about this research, please do not hesitate to contact me [(336) 334-3570 or carrie.wachter@gmail.com]. My faculty advisor, Dr. Craig Cashwell, may also be contacted at cscashwe@ung.edu. For additional information about the rights of participants in research, contact Mr. Eric Allen at (336) 256-1482.

Thank you so much for your assistance and your timely response!

Sincerely,



Carrie A. Wachter, MS, NCC
Doctoral Student
The University of North Carolina at Greensboro

Post Card #2

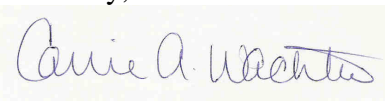
Dear School Counseling Colleague,

Hello! Within the past three weeks, you should have received a survey packet developed to help investigate crisis situations in schools, crisis intervention training of school counselors, and burnout in school counselors. At this point, I have not yet received your response.

Because you were selected from the population of school counselors in North Carolina, your participation in this research opportunity is crucial. *Your perspective is really needed!* In addition, if you complete the survey
and return the contact sheet, you will be entered in a drawing for one of two $50 incentives.

Thank you so much for your time and your participation. If you have any questions or concerns about this research, please do not hesitate to contact me [(336) 334-3570 or carrie.wachter@gmail.com]. My faculty advisor, Dr. Craig Cashwell, may also be contacted at cscashwe@ung.edu. For additional information about the rights of participants in research, contact Mr. Eric Allen at (336) 256-1482.
Thank you so much for your assistance and your timely response!

Sincerely,



Carrie A. Wachter, MS, NCC
Doctoral Candidate
The University of North Carolina at Greensboro

APPENDIX F

REVISED CIDQ FOR MAIN STUDY

Crisis Intervention Descriptive Questionnaire

Definitions Page

These definitions have been compiled through a review of crisis literature and the personal experiences of the researcher.

Suicidal Ideation: Having thoughts of taking one's own life

Suicidal Intent: Having thoughts of taking one's own life including a specific plan and desire to follow through on those thoughts

Suicidal Behavior: Having thoughts of taking one's own life accompanied with an action specifically meant to cause severe harm or death

Self-Injurious Behavior: Inflicting direct harm [causing tissue damage] to oneself without intent to die as a result

Physical Aggression/Bullying: repeated physical attacks or threats of a less powerful person by a more powerful person

Relational Aggression/Bullying: repeated acts or threats intended to cause a victim to feel isolated, ostracized, or shunned

Homicidal Intent: Having thoughts of taking another person's life including a specific plan and desire to follow through on those thoughts

Gang Violence: Physical attacks or threats against a person or persons by an individual or individuals involved in gang activity

Other School Violence: Physical attacks or threats that are not gang-related and do not constitute bullying. This may involve robbery, rape, assault, fighting, homicide, etc.

Physical Abuse: Any physical injury deliberately inflicted on a minor by a caretaker or individual with authority over that child. Physical abuse does not include spanking, but does include discipline that is unreasonable (i.e. punching, hitting a child with a belt or coat hanger)

Sexual Abuse: Any sexual contact of a child by an older person, including rape, molestation, prostitution, having a child watch adult sexual behavior, showing a child pornography, etc.

Neglect: the failure to provide for the child's basic physical, emotional, medical, or educational needs

Severe Mental Health Issues: Any mental health concern that impedes an individual's ability to function. This may include, but is not limited to, depressive disorders, bipolar disorders, eating disorders, psychotic disorders, and dissociative disorders.

Demographic Questionnaire

Please answer the following questions about yourself and your school:

1. Please circle your sex: (1) Female (2) Male

2. What is your age? _____

3. Which of the following best describes your ethnic group? (Circle only one number)

(1) Asian (2) Black (3) Latino
(4) Native American (5) White (6) Multiracial: _____
(7) Other: _____

4. When did you receive your degree(s)?

Degree:	Major:	Year received:
Degree:	Major	Year received:
Degree:	Major:	Year received:

5. When you graduated from your master's program, was your program CACREP-accredited?

(1) Yes (2) No (3) Unsure

6. How many years of experience do you have as a school counselor?

_____ years

7. How long have you worked in your present position? _____ years

8. Not counting yourself, how many other school counselors are on site at your school?
_____ other school counselors

9. What is your school's current student enrollment? _____ students

10. What is the percentage of ethnic minority students at your school? _____

11. What is the percentage of students at your school who receive free or reduced-price lunches? _____

12. What school district is your school located in? _____

13. Does your school have a written crisis plan?

(1) Yes (2) No (3) Unsure

14. What grades does your school serve? _____

15. Please specify membership in organization(s). (Circle all that apply)

ACA ASCA ACES NCCA NCSCA
LPCANC Other (please specify): _____

16. What licenses and certifications do you hold? (Circle all that apply)

NCC NBPTS NCSC LPC
State counseling license _____
(Please indicate all states in which you currently hold licensure)

17. Have you ever been a teacher? (1) Yes (2) No

If yes, how many years? _____

Crisis Intervention Descriptive Questionnaire

PART I: CRISIS EXPERIENCES

1. Which of the following crisis situations have you encountered in your ***career*** as a school counselor? (Please refer to page 1 for definitions of these crisis situations)

Crisis Situation	Yes	No
Suicidal Behavior		
Suicidal Ideation		
Suicidal Intent		
Self-Injurious Behavior		
Physical Aggression/Bullying		
Relational Aggression/Bullying		
Gang Violence		
Other School Violence		
Physical Abuse		
Sexual Abuse		
Child Neglect		
Severe Mental Health Issues		

2. For each situation you selected, approximately how many times have you encountered that situation ***in the past 12 months (1 years)?***

Crisis Situation	Incidents	Crisis Situation	Incidents
Suicidal Behavior		Gang Violence	
Suicidal Ideation		School Violence	
Suicidal Intent		Physical Abuse	
Self-Injurious Behavior		Sexual Abuse	
Physical Aggression/Bullying		Child Neglect	
Relational Aggression/Bullying		Severe Mental Health Issues	

3. Some crisis situations might be seen as more important (i.e. timely intervention may be more vital) and.or more changeable (i.e. intervention is more likely to have a <u>positive</u> impact on the crisis situation).

   For the following crises, PLEASE RANK ORDER the crises listed in terms of 1) importance and 2) changeability. A ranking of 1 would indicate HIGHEST level of importance or changeability, and a ranking of 12 would indicate LOWEST level of importance or changeability.

Crisis Situation	Import	Change	Crisis Situation	Import	Change
Suicidal Behavior			Gang Violence		
Suicidal Ideation			Other School Violence		
Suicidal Intent			Physical Abuse		
Self-Injurious Behavior			Sexual Abuse		
Physical Aggression/Bullying			Child Neglect		
Relational Aggression/Bullying			Severe Mental Health Issues		

4. How effective are you when working with crisis issues? (Please circle one)

Not Effective Slightly Effective Effective Very Effective

PART II: CRISIS TRAINING

5. Have you taken a semester-long course that specifically dealt with crisis and/or crisis intervention?

Yes, it was required for my Master's program Yes, in my Master's program
Yes, after I received my Master's Yes, both during and receiving my Master's
No, it was offered, but I didn't take it No, it was not offered

6. Please specify which topics were covered in your crisis and/or crisis intervention course(s). If a topic was covered, select Yes. If it was not covered, select No.

Master's Crisis Course			Post-Master's Crisis Course		
Crisis	Yes	No	Crisis	Yes	No
Suicidal Behavior			Suicidal Behavior		
Suicidal Ideation			Suicidal Ideation		
Suicidal Intent			Suicidal Intent		
Self-Injurious Behavior			Self-Injurious Behavior		
Physical Aggression/Bullying			Physical Aggression/Bullying		
Relational Aggression/Bullying			Relational Aggression/Bullying		
Gang Violence			Gang Violence		
School Violence			School Violence		
Physical Abuse			Physical Abuse		
Sexual Abuse			Sexual Abuse		
Child Neglect			Child Neglect		
Severe Mental Health Issues			Severe Mental Health Issues		

For the next two sections, please use the following scales to indicate the type of training you completed, the number of times you completed that training, how helpful you perceive that training has been, and when your most recent training in each area was.

Training: A = No training
B = Training integrated into coursework
C = Presentation/Workshop (less than 3 hours)
D = Single Day Workshop (more than 3 hours)
E = Multi-Day Workshop
F = Other (please specify)

Helpfulness: 1 = Not helpful
2 = Slightly helpful
3 = Helpful
4 = Very helpful

For example, if you had completed 2 presentations that were Helpful and a multi-day workshop that was Not helpful in "Juggling," and your most recent training was in 2004, you would fill out the chart as follows:

Topic	Type	Amount	Helpfulness	Most recent training
Juggling	C	2	3	2004
	E	1	1	

7. MASTER'S DEGREE TRAINING:

Please describe your MASTER'S DEGREE crisis training experiences on the following topics in the chart below.

Training: A = No training
B = Training integrated into coursework
C = Presentation/Workshop (less than 3 hours)
D = Single Day Workshop (more than 3 hours)
E = Multi-Day Workshop
F = Other (please specify)

Helpfulness: 1 = Not helpful
2 = Slightly helpful
3 = Helpful
4 = Very helpful

Topic	Type	Amount	Helpfulness	Most recent training
Suicide, Suicidal Behavior, and Suicidal Ideation				
Self-Injurious Behavior				
Physical and/or Relational Bullying				
Gang Violence or School Violence (Not including Bullying)				
Child Abuse and/or Neglect				
Severe Mental Health Issues				
Critical Incident Stress Debriefing				
Other (please specify)				
Other (please specify)				

8. POST MASTER'S DEGREE TRAINING:

Please describe your POST-MASTER'S crisis training experiences on the following topics in the chart below.

Training: A = No training
B = Training integrated into coursework
C = Presentation/Workshop (less than 3 hours)
D = Single Day Workshop (more than 3 hours)
E = Multi-Day Workshop
F = Other (please specify)

Helpfulness: 1 = Not helpful
2 = Slightly helpful
3 = Helpful
4 = Very helpful

Topic	Type	Amount	Helpfulness	Most recent training
Suicide, Suicidal Behavior, and Suicidal Ideation				
Self-Injurious Behavior				
Physical and/or Relational Bullying				
Gang Violence or School Violence (Not including Bullying)				
Child Abuse and/or Neglect				
Severe Mental Health Issues				
Critical Incident Stress Debriefing				
Other (please specify)				
Other (please specify)				

PART III: RESOURCES

9. For each of the following resources below that may support you in the crisis intervention process, please indicate the usefulness of each resource in helping and/or supporting you in the crisis intervention process.

Not Useful 1 | Slightly Useful 2 | Useful 3 | Very Useful 4

Physical Resources	N/A	1	2	3	4
Textbooks	N/A	1	2	3	4
Journal articles	N/A	1	2	3	4
Websites	N/A	1	2	3	4
Crisis Intervention Manuals	N/A	1	2	3	4
District Crisis Plan	N/A	1	2	3	4
Other Counselors at your School	N/A	1	2	3	4
Administrators	N/A	1	2	3	4
School Social Worker	N/A	1	2	3	4
School Nurse	N/A	1	2	3	4
School Psychologist	N/A	1	2	3	4
Teachers	N/A	1	2	3	4
Teachers of Exceptional Students	N/A	1	2	3	4
Student Resource Officer (SRO)	N/A	1	2	3	4
Director of Student Services	N/A	1	2	3	4
Central Office Personnel	N/A	1	2	3	4
School Counselors at Other Schools	N/A	1	2	3	4
Community Counselors	N/A	1	2	3	4
Psychologists	N/A	1	2	3	4
Psychiatrists	N/A	1	2	3	4
School Counselor Educators	N/A	1	2	3	4
Hotline/Crisis Phone Specialists	N/A	1	2	3	4
Law Enforment (besides SROs)	N/A	1	2	3	4
Magistrate	N/A	1	2	3	4
Lawyer/Attorney	N/A	1	2	3	4
Other (Please specify and rate usefulness)	N/A	1	2	3	4
	N/A	1	2	3	4
	N/A	1	2	3	4
	N/A	1	2	3	4
	N/A	1	2	3	4

10. If there are any resources you have found particularly helpful (i.e. specific textbooks, websites, journals, etc.) please list them below.

PART IV: SKILLS

11. Understanding that it would be impossible to perform each of these tasks in a typical workday, please rate the following:

a). How necessary it is for school counselors to have the following skills in order to effectively intervene in crisis situations?

Unnecessary	Somewhat Necessary	Necessary	Vital
1	2	3	4

b). How comfortable you are in performing the following skills?

Not at all	Somewhat Comfortable	Comfortable	Very Comfortable
1	2	3	4

For example, if you think that the ability to hop on one leg is necessary and you feel somewhat comfortable hopping on one leg, you would answer the question as follows

The ability to…	Necessity				Comfort			
Hop on one leg	1	2	(3)	4	1	(2)	3	4

Necessity Scale: Unnecessary 1 Somewhat Necessary 2 Necessary 3 Vital 4

Comfort Scale: Not at all 1 Somewhat Comfortable 2 Comfortable 3 Very Comfortable 4

The ability to…	Necessity				Comfort			
Actively listen to the student	1	2	3	4	1	2	3	4
Appropriately document concerns and procedures	1	2	3	4	1	2	3	4
Assess potential danger to self and others	1	2	3	4	1	2	3	4
Communicate with other mental health providers using DSM language	1	2	3	4	1	2	3	4
Conduct a thorough risk assessment including relevant history, precipitating events, current status (presence of ideation, plan, etc.), and current mental status exam	1	2	3	4	1	2	3	4
Consult with administration in managing a crisis situation	1	2	3	4	1	2	3	4
Consult with school counseling peers in managing crisis situation	1	2	3	4	1	2	3	4
Coordinate implementation of a crisis prevention program	1	2	3	4	1	2	3	4

Necessity Scale: Unnecessary 1 Somewhat Necessary 2 Necessary 3 Vital 4

Comfort Scale: Not at all 1 Somewhat Comfortable 2 Comfortable 3 Very Comfortable 4

The ability to…	Necessity				Comfort			
Create a nonjudgmental environment for crisis intervention	1	2	3	4	1	2	3	4
Demonstrate appropriate interviewing skills	1	2	3	4	1	2	3	4
Demonstrate de-escalation skills (e.g. calming, reduction of anxiety, reduction of agitation, etc.)	1	2	3	4	1	2	3	4
Develop a crisis prevention program	1	2	3	4	1	2	3	4
Distinguish self-injurious behavior from suicidal behavior	1	2	3	4	1	2	3	4
Establish achievable goals with the student	1	2	3	4	1	2	3	4
Evaluate mental status and assess potential causes for diminished mental health status	1	2	3	4	1	2	3	4
Evaluate the potential for a behavioral emergency	1	2	3	4	1	2	3	4
Evaluate the potential for a medical emergency	1	2	3	4	1	2	3	4
Explain community resources and procedures to parents/guardians (for example – in cases needing involuntary commitment, referral to other levels of care)	1	2	3	4	1	2	3	4
Explain community resources and procedures to students (for example – in cases needing involuntary commitment, referral to other levels of care)	1	2	3	4	1	2	3	4
Explain school crisis plan to school stakeholders	1	2	3	4	1	2	3	4
Facilitate the student's expression of emotions	1	2	3	4	1	2	3	4
Focus counseling on the precipitating event	1	2	3	4	1	2	3	4
Help the student develop adaptive coping skills and identify additional sources of support	1	2	3	4	1	2	3	4
Identify a history of the student's usual coping skills	1	2	3	4	1	2	3	4
Identify ethical dilemmas or challenges related to school crisis plan	1	2	3	4	1	2	3	4
Identify parties who may need follow-up services after a crisis	1	2	3	4	1	2	3	4
Identify people who may need debriefing after a crisis	1	2	3	4	1	2	3	4
Identify pertinent data for inclusion in reports	1	2	3	4	1	2	3	4
Identify physical bullying behaviors	1	2	3	4	1	2	3	4
Identify presence of gangs on campus	1	2	3	4	1	2	3	4
Identify relational bullying behaviors	1	2	3	4	1	2	3	4

Necessity Scale: Unnecessary 1 | Somewhat Necessary 2 | Necessary 3 | Vital 4

Comfort Scale: Not at all 1 | Somewhat Comfortable 2 | Comfortable 3 | Very Comfortable 4

The ability to…	Necessity				Comfort			
Identify students exhibiting indicators of common mental health problems (e.g., adjustment disorders, mood disorders, anxiety disorders, ADHD)	1	2	3	4	1	2	3	4
Identify students exhibiting indicators of homicidal ideation/violence	1	2	3	4	1	2	3	4
Identify students exhibiting indicators of physical abuse	1	2	3	4	1	2	3	4
Identify students exhibiting indicators of psychosis	1	2	3	4	1	2	3	4
Identify students exhibiting indicators of severe mental health issues? (e.g., bipolar disorder, psychotic disorders, conduct disorder…)	1	2	3	4	1	2	3	4
Identify students exhibiting indicators of sexual abuse	1	2	3	4	1	2	3	4
Identify students exhibiting indicators of suicidal ideation and suicidal intent	1	2	3	4	1	2	3	4
Identify the precipitating event (stressor) and the student's reactions to it	1	2	3	4	1	2	3	4
Implement adaptive self-care behavior during crisis intervention and postvention	1	2	3	4	1	2	3	4
Initiate contact with parents of student(s) in crisis	1	2	3	4	1	2	3	4
Initiate procedures to involve others (e.g., school resource officer, special education teacher) who may assist during crisis incident	1	2	3	4	1	2	3	4
Initiate procedures to keep a student safe during crisis intervention (e.g., appropriate supervision of student expressing suicidal ideation, threatening violence)	1	2	3	4	1	2	3	4
Intervene in physical bullying behaviors	1	2	3	4	1	2	3	4
Intervene in relational bullying behaviors	1	2	3	4	1	2	3	4
Make decisions about breaking vs. maintaining confidentiality	1	2	3	4	1	2	3	4
Make DSS/CPS reports	1	2	3	4	1	2	3	4
Make ethical decisions related to school crisis	1	2	3	4	1	2	3	4
Make referrals to appropriate levels of care in the community (i.e. outpatient, intensive outpatient, inpatient)	1	2	3	4	1	2	3	4
Normalize the student's emotional reactions to the event, when appropriate	1	2	3	4	1	2	3	4
Provide appropriate follow-up services after a crisis	1	2	3	4	1	2	3	4

Necessity Scale: Unnecessary 1 Somewhat Necessary 2 Necessary 3 Vital 4

Comfort Scale: Not at all 1 Somewhat Comfortable 2 Comfortable 3 Very Comfortable 4

The ability to…	Necessity				Comfort			
Provide comprehensive case presentation for peers/administrators	1	2	3	4	1	2	3	4
Provide Critical Incident Stress Debriefing	1	2	3	4	1	2	3	4
Provide psychoeducation about the crisis	1	2	3	4	1	2	3	4
Provide support to the student	1	2	3	4	1	2	3	4
Provide support to those close to the student	1	2	3	4	1	2	3	4
Quickly consult with parents and friends of the student in order to gather any additional information	1	2	3	4	1	2	3	4
Quickly establish a rapport with a student	1	2	3	4	1	2	3	4
Seek supervision in managing crisis situation	1	2	3	4	1	2	3	4
Self-monitor personal reactions	1	2	3	4	1	2	3	4
Use therapeutic, mediation, negotiation, anger management and conflict resolution skills to handle difficult situations	1	2	3	4	1	2	3	4
Use understanding of benefits and risks associated with no-harm contracts to initiate appropriate plans	1	2	3	4	1	2	3	4
Work independently, utilizing technology to communicate and facilitate interaction	1	2	3	4	1	2	3	4
Write summaries of assessment and other supporting data for documentation	1	2	3	4	1	2	3	4
Other (please specify and rate necessity)	1	2	3	4	1	2	3	4
	1	2	3	4	1	2	3	4
	1	2	3	4	1	2	3	4
	1	2	3	4	1	2	3	4
	1	2	3	4	1	2	3	4

12. Please take a moment to describe any reactions you might have had while responding to the above list of skills.

Please use the following scale to answer the question:
When you think about your work overall, how often do you feel the following?

1 never	2 almost never	3 rarely	4 sometimes	5 often	6 very often	7 always
Tired	1	2	3	4	5	6	7
Disappointed with people	1	2	3	4	5	6	7
Hopeless	1	2	3	4	5	6	7
Trapped	1	2	3	4	5	6	7
Helpless	1	2	3	4	5	6	7
Depressed	1	2	3	4	5	6	7
Physically weak/Sickly	1	2	3	4	5	6	7
Worthless/Like a failure	1	2	3	4	5	6	7
Difficulties sleeping	1	2	3	4	5	6	7
“I’ve had it”	1	2	3	4	5	6	7

APPENDIX G

FACTOR LOADINGS OF SKILLS NECESSITY AND SKILLS COMFORT SCALE

Skill	Component	
	Necessity	Comfort
s35n	.721	
s26n	.715	
s36n	.694	
s51n	.689	
s40n	.683	
s33n	.678	
s50n	.673	
s39n	.665	
s28n	.660	
s54n	.647	
s27n	.643	
s62n	.633	
s14n	.626	
s53n	.619	
s30n	.617	
s37n	.616	
s34n	.614	
s60n	.612	
s46n	.610	
s52n	.608	
s18n	.607	
s25n	.606	
s24n	.605	
s31n	.597	
s16n	.595	
s15n	.591	
s61n	.584	
s38n	.580	
s32n	.576	
s64n	.559	
s48n	.552	
s23n	.551	
s57n	.550	
s42n	.549	
s13n	.546	
s63n	.538	
s19n	.536	
s45n	.527	
s12n	.521	
s49n	.517	

s8n	.502	
s56n	.498	
s44n	.498	
s20n	.497	
s41n	.492	
s29n	.490	
s55n	.478	
s17n	.476	
s22n	.474	
s59n	.466	
s47n	.466	
s5n	.460	
s3n	.457	
s2n	.406	
s58n	.397	
s21n	.392	
s11n	.391	
s43n	.378	
s6n	.371	
s9n	.355	
s38c		.680
s43c		.655
s57c		.655
s64c		.651
s16c		.647
s27c		.642
s54c		.628
s25c		.626
s13c		.623
s53c		.622
s32c		.611
s51c		.608
s8c		.602
s26c		.599
s41c		.595
s49c		.593
s3c		.591
s24c		.583
s22c		.580
s52c		.574
s15c		.572
s61c		.571
s11c		.571
s23c		.565

s42c		.561
s62c		.560
s39c		.559
s19c		.553
s40c		.552
s37c		.549
s50c		.547
s4c		.542
s46c		.539
s29c		.536
s35c		.533
s34c		.532
s2c		.530
s12c		.529
s48c		.518
s30c		.507
s21c		.505
s17c		.498
s36c		.495
s10c		.494
s20c		.480
s56c		.479
s5c		.474
s18c		.465
s45c		.461
s60c		.459
s44c		.453
s63c		.446
s14c		.442
s7c		.419
s31c		.418
s55c		.418
s59c		.400
s47c		.394
s9c		.369
s58c		.324

Extraction Method: Principal Component Analysis.
Rotation Method: Varimax with Kaiser Normalization.

APPENDIX H

ITEMIZED DESCRIPTIVE STATISTICS OF REVISED SKILLS NECESSITY AND SKILLS COMFORT ITEMS

Descriptive Statistics: Skills Necessity Items

	N	Minimum	Maximum	*M*	*SD*
Appropriately document concerns and procedures	129	2.00	4.00	3.57	0.57
Assess potential danger to self and others	129	2.00	4.00	3.87	0.36
Conduct a thorough risk assessment including relevant history, precipitating events, current status (presence of ideation, plan, etc.), and current mental status exam	129	1.00	4.00	3.17	0.90
Consult with administration in managing a crisis situation	130	2.00	4.00	3.75	0.45
Coordinate implementation of a crisis prevention program	130	1.00	4.00	3.42	0.64
Create a nonjudgmental environment for crisis intervention	130	2.00	4.00	3.65	0.54
Demonstrate de-escalation skills (e.g., calming, reduction of anxiety, reduction of agitation, etc)	130	2.00	4.00	3.71	0.47
Develop a crisis prevention program	130	1.00	4.00	3.39	0.68
Distinguish self-injurious behavior from suicidal behavior	128	1.00	4.00	3.48	0.61
Establish achievable goals with the student	130	1.00	4.00	3.41	0.57
Evaluate mental status and assess potential causes for diminished mental health status	128	1.00	4.00	3.05	0.74
Evaluate the potential for a behavioral emergency	130	1.00	4.00	3.46	0.65
Evaluate the potential for a medical emergency	130	1.00	4.00	3.38	0.71
Explain community resources and procedures to	130	2.00	4.00	3.44	0.56

parents/guardians (for example – in cases needing involuntary commitment, referral to other levels of care)					
Explain community resources and procedures to students (for example – in cases needing involuntary commitment, referral to other levels of care)	130	2.00	4.00	3.29	0.62
Explain school crisis plan to school stakeholders	130	2.00	4.00	3.12	0.68
Facilitate the student's expression of emotions	130	2.00	4.00	3.45	0.62
Focus counseling on the precipitating event	129	1.00	4.00	3.17	0.70
Help the student develop adaptive coping skills and identify additional sources of support	128	2.00	4.00	3.55	0.53
Identify a history of the student's usual coping skills	130	1.00	4.00	3.25	0.60
Identify ethical dilemmas or challenges related to school crisis plan	130	1.00	4.00	3.10	0.69
Identify parties who may need follow-up services after a crisis	130	1.00	4.00	3.46	0.61
Identify people who may need debriefing after a crisis	129	1.00	4.00	3.42	0.61
Identify pertinent data for inclusion in reports	130	1.00	4.00	3.01	0.73
Identify physical bullying behaviors	129	2.00	4.00	3.54	0.56
Identify presence of gangs on campus	130	1.00	4.00	3.41	0.71
Identify relational bullying behaviors	130	2.00	4.00	3.49	0.56
Identify students exhibiting indicators of common mental health problems (eg, adjustment disorders, mood disorders, anxiety disorders,	129	2.00	4.00	3.16	0.67

ADHD)					
Identify students exhibiting indicators of homicidal ideation/violence	129	1.00	4.00	3.55	0.62
Identify students exhibiting indicators of physical abuse	129	1.00	4.00	3.71	0.52
Identify students exhibiting indicators of psychosis	129	1.00	4.00	3.43	0.70
Identify students exhibiting indicators of severe mental health issues? (e.g., bipolar disorder, psychotic disorders, conduct disorder…)	129	2.00	4.00	3.40	0.69
Identify students exhibiting indicators of sexual abuse	129	2.00	4.00	3.66	0.54
Identify students exhibiting indicators of suicidal ideation and suicidal intent	128	3.00	4.00	3.80	0.40
Identify the precipitating event (stressor) and the student's reactions to it	129	1.00	4.00	3.33	0.56
Implement adaptive self-care behavior during crisis intervention and postvention	126	1.00	4.00	3.21	0.68
Initiate contact with parents of student(s) in crisis	129	3.00	4.00	3.80	0.40
Initiate procedures to involve others (e.g., school resource officer, special education teacher) who may assist during crisis incident	127	2.00	4.00	3.65	0.53
Initiate procedures to keep a student safe during crisis intervention (e.g., appropriate supervision of student expressing suicidal ideation, homicidal ideation)	129	2.00	4.00	3.78	0.44
Intervene in physical bullying behaviors	129	1.00	4.00	3.52	0.59
Intervene in relational bullying behaviors	127	1.00	4.00	3.51	0.56
Make decisions about breaking versus maintaining confidentiality	129	2.00	4.00	3.62	0.52

Make DSS/CPS reports	127	1.00	4.00	3.69	0.56
Make ethical decisions related to school crisis	127	2.00	4.00	3.57	0.56
Make referrals to appropriate levels of care in the community (i.e., outpatient, intensive outpatient, inpatient)	129	1.00	4.00	3.36	0.69
Normalize the student's emotional reactions to the event, when appropriate	129	2.00	4.00	3.36	0.56
Provide appropriate follow-up services after a crisis	129	2.00	4.00	3.45	0.56
Provide comprehensive case presentation for peers/administrators	130	1.00	4.00	2.60	0.85
Provide Critical Incident Stress Debriefing	129	1.00	4.00	3.07	0.78
Provide psychoeducation about the crisis	126	1.00	4.00	2.75	0.84
Provide support to the student	130	2.00	4.00	3.80	0.42
Provide support to those close to the student	128	2.00	4.00	3.49	0.56
Quickly consult with parents and friends of the student in order to gather any additional information	128	2.00	4.00	3.47	0.64
Quickly establish a rapport with a student	130	2.00	4.00	3.75	0.47
Seek supervision in managing crisis situation	130	1.00	4.00	3.38	0.71
Self-monitor personal reactions	127	1.00	4.00	3.43	0.65
Use therapeutic, mediation, negotiation, anger management and conflict resolution skills to handle difficult situations	130	2.00	4.00	3.45	0.57
Use understanding of benefits and risks associated with no-harm contracts to initiate appropriate plans	129	1.00	4.00	3.17	0.75

Work independently, utilizing technology to communicate and facilitate interaction	130	1.00	4.00	2.84	0.92
Write summaries of assessment and other supporting data for documentation	130	1.00	4.00	2.97	0.76

Descriptive Statistics: Skills Comfort Items

Skill	N	Min	Max	*M*	*SD*
Appropriately document concerns and procedures	129	2.00	4.00	3.36	0.70
Assess potential danger to self and others	129	1.00	4.00	3.43	0.65
Communicate with other mental health providers using DSM language	127	1.00	4.00	2.63	0.90
Conduct a thorough risk assessment including relevant history, precipitating events, current status (presence of ideation, plan, etc), and current mental status exam	130	1.00	4.00	2.51	0.93
Consult with school counseling peers in managing crisis situation	130	2.00	4.00	3.65	0.55
Coordinate implementation of a crisis prevention program	130	1.00	4.00	2.98	0.78
Create a nonjudgmental environment for crisis intervention	130	1.00	4.00	3.50	0.59
Demonstrate appropriate interviewing skills	130	2.00	4.00	3.42	0.62
Demonstrate de-escalation skills (e.g., calming, reduction of anxiety, reduction of agitation, etc)	130	2.00	4.00	3.42	0.66
Develop a crisis prevention program	130	1.00	4.00	2.85	0.74
Distinguish self-injurious behavior from suicidal behavior	128	1.00	4.00	2.96	0.79
Establish achievable goals with the student	130	1.00	4.00	3.32	0.65
Evaluate mental status and assess potential causes for diminished mental health status	128	1.00	4.00	2.51	0.90
Evaluate the potential for a behavioral emergency	130	1.00	4.00	2.84	0.81
Evaluate the potential for a medical emergency	130	1.00	4.00	2.64	0.86
Explain community resources and procedures to parents/guardians (for example – in cases needing involuntary commitment, referral to other levels of care)	130	1.00	4.00	2.92	0.83
Explain community resources and procedures to students (for example – in cases needing involuntary commitment, referral to other levels of care)	130	1.00	4.00	2.89	0.80
Explain school crisis plan to school stakeholders	130	1.00	4.00	2.84	0.83
Facilitate the student's expression of emotions	130	1.00	4.00	3.40	0.64
Focus counseling on the precipitating	129	1.00	4.00	3.28	0.64

event					
Help the student develop adaptive coping skills and identify additional sources of support	128	1.00	4.00	3.28	0.65
Identify a history of the student's usual coping skills	130	1.00	4.00	3.10	0.70
Identify ethical dilemmas or challenges related to school crisis plan	130	1.00	4.00	2.82	0.76
Identify parties who may need follow-up services after a crisis	130	1.00	4.00	3.12	0.70
Identify people who may need debriefing after a crisis	129	1.00	4.00	3.09	0.74
Identify physical bullying behaviors	129	2.00	4.00	3.31	0.62
Identify presence of gangs on campus	130	1.00	4.00	2.55	0.92
Identify relational bullying behaviors	130	1.00	4.00	3.09	0.74
Identify students exhibiting indicators of common mental health problems (e.g., adjustment disorders, mood disorders, anxiety disorders, ADHD)	129	1.00	4.00	2.88	0.81
Identify students exhibiting indicators of physical abuse	129	2.00	4.00	3.17	0.72
Identify students exhibiting indicators of psychosis	129	1.00	4.00	2.47	0.91
Identify students exhibiting indicators of severe mental health issues? (e.g., bipolar disorder, psychotic disorders, conduct disorder…)	129	1.00	4.00	2.50	0.90
Identify students exhibiting indicators of sexual abuse	128	1.00	4.00	2.88	0.77
Identify students exhibiting indicators of suicidal ideation and suicidal intent	128	1.00	4.00	3.05	0.77
Identify the precipitating event (stressor) and the student's reactions to it	129	1.00	4.00	3.03	0.71
Implement adaptive self-care behavior during crisis intervention and postvention	126	1.00	4.00	2.79	0.83
Initiate contact with parents of student(s) in crisis	129	1.00	4.00	3.53	0.63
Initiate procedures to involve others (e.g., school resource officer, special education teacher) who may assist during crisis incident	127	2.00	4.00	3.50	0.64
Initiate procedures to keep a student safe during crisis intervention (e.g., appropriate supervision of student expressing suicidal ideation, homicidal ideation)	129	1.00	4.00	3.46	0.71
Intervene in physical bullying behaviors	129	1.00	4.00	3.03	0.84
Intervene in relational bullying behaviors	127	1.00	4.00	3.15	0.79
Make decisions about breaking versus	129	1.00	4.00	3.21	0.70

maintaining confidentiality					
Make DSS/CPS reports	127	1.00	4.00	3.52	0.75
Make ethical decisions related to school crisis	127	2.00	4.00	3.22	0.71
Make referrals to appropriate levels of care in the community (i.e., outpatient, intensive outpatient, inpatient)	129	1.00	4.00	2.88	0.87
Normalize the student's emotional reactions to the event, when appropriate	129	1.00	4.00	3.15	0.66
Provide appropriate follow-up services after a crisis	129	1.00	4.00	3.07	0.73
Provide comprehensive case presentation for peers/administrators	130	1.00	4.00	2.66	0.83
Provide Critical Incident Stress Debriefing	129	1.00	4.00	2.47	0.91
Provide psychoeducation about the crisis	126	1.00	4.00	2.36	0.87
Provide support to those close to the student	127	2.00	4.00	3.44	0.60
Quickly consult with parents and friends of the student in order to gather any additional information	128	1.00	4.00	3.41	0.67
Quickly establish a rapport with a student	130	2.00	4.00	3.63	0.54
Seek supervision in managing crisis situation	130	1.00	4.00	3.38	0.65
Self-monitor personal reactions	128	2.00	4.00	3.28	0.60
Use therapeutic, mediation, negotiation, anger management and conflict resolution skills to handle difficult situations	130	1.00	4.00	3.22	0.66
Use understanding of benefits and risks associated with no-harm contracts to initiate appropriate plans	129	1.00	4.00	2.77	0.90
Work independently, utilizing technology to communicate and facilitate interaction	130	1.00	4.00	2.85	0.92
Write summaries of assessment and other supporting data for documentation	130	1.00	4.00	2.80	0.88